DCH Diabetes and Nutrition Education Center

Initial Visit Assessment

DT0024

Name: _____Height: _____ Weight: _____

Visitor Attending _____ Relationship_____

Ethnic Background: ☐ Black/African American ☐White/Caucasian ☐ Hispanic

☐Native American ☐Middle-eastern ☐Other: _____

Preferred Language: ☐ English ☐Other: _____

How long have you been diagnosed with Diabetes? _____ What Type? ☐ Type 1 ☐ Type 2

☐ Other:_____

Has anyone else in your family been diagnosed with diabetes? ☐Y / ☐N

Who? (mother, father, etc.) _____

Previous Diabetes Education: ☐Y / ☐N When:_____ Where:_____

Medical History: Check all that apply

☐	Hypertension	☐	Heart Disease	☐	Eye Disease	☐	Sexual problems	☐	
☐	High Cholesterol	☐	Heart Attack	☐	Kidney Disease	☐	Depression	☐	
☐	Sleep Apnea	☐	Angioplasty	☐	Neuropathy	☐	Cancer	☐	
☐	Stroke	☐	Cardiac Stents	☐	Dental disease	☐	Thyroid Disease	☐	

Other medical conditions/ surgeries:_____

_____

_____

Tests/procedures in past 12 months: (Check all that apply)

☐	Dilated eye exam	☐	Urine test	☐	Foot exam	☐	Dental exam	☐	A1c
☐	Flu shot	☐	Pneumonia shot	☐	Sleep study	☐	Blood pressure	☐	Cholesterol

Emergency Room visit in past 12 months: ☐Y / ☐N Reason:_____

Admitted to Hospital in past 12 months: ☐Y / ☐N Reason:_____

Primary Care Physician visit in past 12 months: ☐Y / ☐N

Tobacco Use: ☐Y / ☐N / ☐Quit (when?)_____

Type:_____ How much/often:_____

Alcohol Use: ☐ Y / ☐N / ☐Quit (when?)_____

Type:_____ How much/often:_____

Exercise: ☐Y / ☐N What type:_____ How much/often:_____

Interested in: ☐Weight loss/ Goal: _____lbs. ☐Weight gain ☐Weight Maintenance

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Medication:

For Diabetes:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Do you have any difficulty taking your medications on schedule and as prescribed? ☐ No ☐ Yes

Why?_____

How often are doses missed?_____

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Monitoring:

How often do you monitor your blood sugar level: ☐ _____ times per day ☐ _____times per week

☐Occasionally ☐ I do not monitor my blood sugar Blood sugar Range: _____ to _____

Do you have any difficulty checking your blood sugar on schedule? ☐ No ☐ Yes, Why?_____

Name of meter:_____ How old is your meter?_____

How often do you have a **low blood sugar level**? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

What symptoms do you have? _____

What is your usual treatment for a low blood sugar? _____

How often do you have a **high blood sugar level**? ☐ Daily ☐ Weekly ☐ Occasionally ☐ Never

What symptoms do you have? _____

What is your usual treatment for a high blood sugar level? _____

Social/Stress Factors:

Occupation: _____

Last level of education completed: _____

Diabetes support person(s):_____

# of household members:_____ Relation to patient:_____

Do you have any difficulty with: ☐Hearing ☐Seeing ☐Reading ☐ Speaking

Please explain:_____

How do you learn something new the best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing/hands on

Stress level: ☐Low ☐Moderate ☐High. What are the major stressors:_____

_____

What do you do to manage your stress?_____

Main concern about having diabetes:_____

How do you feel about having diabetes? _____

Are you ready to make lifestyle changes? ☐ Y / ☐N / ☐Unsure

How do you think your diabetes treatment is going? ☐ Great – I'm totally on top of it! ☐ Okay – but I could do better ☐ Not great – I'm stuck!

What are the biggest challenges you have in taking care of your diabetes? ☐ Remembering to take my medication ☐ Eating healthfully ☐ Paying for medications ☐ Making and getting to appointments ☐ Being physically active ☐ Feeling overwhelmed or depressed

Do you have any Cultural or religious beliefs that influence how you manage your diabetes? If so, please explain:_____

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Meal Planning

Please give a sample of your meals for the past 24 hours (including drinks):

1st meal Time:_____	2nd meal Time:_____	3rd meal Time:_____
Snack Time:_____	Snack Time:_____	Snack Time:_____

Who is the grocery shopper at home? ☐Self / ☐Other:_____

Who is the primary cook at home: ☐Self / ☐Other:_____

How often are meals eaten out:_____

Do you read food labels: ☐Yes / ☐No

Which meal time(s) do you typically skip: ☐ Breakfast ☐Lunch ☐Dinner ☐None

List any dietary restrictions:_____

_____