Winter Haven Hospital

Name: ____________________ Date of Birth: ____________ Age: ________

Address: ____________________ Phone: Home: ____________________

City: ____________________ Work: ____________________

State: ________ Zip: ________ Cell / Other: ____________________

E-mail Address: ____

MAY WE E-MAIL INFORMATION TO YOU? ☐ Yes ☐ No

Physician Name: ____________________ Physician Address: ____________________

Statistical Data: **Sex:** ☐ M ☐ F **Primary Language:** ____________________

Marital Status: ☐ Single ☐ Married / Partnered ☐ Divorced ☐ Widowed

Living: ☐ Alone ☐ With others

Ethnic Group (check all that apply): ☐ African American / Black ☐ Caucasian ☐ Latino

☐ Asian / Pacific Islander ☐ Native American ☐ Middle Eastern ☐ Other (specify): ____________

Employed: ☐ Yes ☐ No ☐ Retired What is / was your occupation? ____________

Health Insurance: ☐ Yes ☐ No Name of your health insurance? ____________

The ways you learn best:	**Barriers / Difficulties**
☐ Discussion	☐ Visual ____________
☐ Reading	☐ Hearing ____________
☐ Lecture	☐ Reading / Writing ____________
☐ Hands On	☐ Understanding what you read ____________
☐ Video / TV / Computer	☐ Physical difficulties ____________
☐ Other ____________	☐ Other ____________

Your Diabetes Is:

☐ Type 1 ☐ Type 2

☐ Gestational ☐ Other ____________

☐ I don't know

When Diagnosed: ________ **Age at Diagnosis:** ________

Do you have family with diabetes? ☐ Yes ☐ No

If yes, who? ____________

What type? ____________

Management of Diabetes:

What do you use to manage your diabetes?

☐ Diet ☐ Exercise ☐ Pills ☐ Insulin ☐ Other Injection ☐ Other ____________

Were you taught to take care of diabetes?

If yes, when? ____________ Who taught you? ____________

WHH - 4134 Rev: 12/11

ADULT DIABETES ASSESSMENT RECORD

Center for Diabetes Education
Winter Haven Hospital, Inc.
Winter Haven, FL 33881

Nutrition: Do you follow a food plan / diet? ☐ Yes ☐ No Type of plan: ____________

What do you drink for thirst? ____________ Who cooks at home? ____________

How many times a week do you eat fried foods?

☐ Never ☐ 1 or 2 times a week ☐ More than 2 times a week

How many times a week do you eat out? ____________ Type of restaurant? ____________

Do you eat breakfast or within 1-2 hours of waking up? ☐ Yes ☐ No

How many meals or snacks do you eat a day and at what times?

Meals #: ______ Times: ____________ Snacks #: ______ Times: ____________

Typical Breakfast	Typical Lunch	Typical Supper	Typical Snack
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Alcohol: ☐ Yes ☐ No Drinks per week: ____________

What is your height? ________ What do you weigh? ____________

What did you weigh last year? ____________ What would you like to weigh? ____________

If your weight changed in the last year, what is the reason? ____________

Exercise and Physical Activity:

Do you exercise? ☐ Yes ☐ No Regularly? ☐ Yes ☐ No If yes, how many times / week? ____________

How many minutes each time? ____________ What type(s)? ____________

Do you exercise: ☐ alone ☐ with someone? With whom? ____________

If you do not exercise, what it is the reason? ____________

Do you have to limit your activities / exercise in any way? ☐ Yes ☐ No

If yes, please explain: ____________

Home Diabetes Testing:

Do you test your blood glucose (sugar)? ☐ Yes ☐ No

How often? ________ Meter Name ____________

Do you write down your results? ☐ Yes ☐ No

Usual results ____________

What should your results be? ____________

When do you test?

☐ Before eating in the morning ☐ Before meals

☐ At bedtime ☐ After meals

☐ With exercise ☐ Other times ________

What do you do with your used lancets / needles: ________

Did you ever have high blood glucose (high sugar)? ☐ Yes ☐ No

If yes, when / how did you take care of it? ____________

____

Why did this happen? ____________

Did you test urine for ketones? ☐ Yes ☐ No

If yes, did you have ketones? ☐ Yes ☐ No

or ketoacidosis? ☐ Yes ☐ No

If yes, how was it treated? ____________

Did you ever have low blood glucose (low sugar)? ☐ Yes ☐ No

If yes, when / how did you take care of it? ____________

____

Why did this happen? ____________

Medicines for Diabetes (pills)

Name	Dose	Time Taken
___	___	___
___	___	___
___	___	___

Medicines for Diabetes (insulin or other injection)

Name ___ Amount ___ When taken ___

Name ___ Amount ___ When taken ___

Who prepares the injections and gives the medicine? ___

How do you take your medicine? Using ☐ Vial and syringes ☐ Pen ☐ Pump

Where (in your body) do you inject? ___ Where do you store the medicine? ___

After opening, how long do you keep the medicine? ___

Reuse syringes ☐ Yes ☐ No What do you do with your used syringes: ___

Medicine for other conditions, prescription, over-the-counter and supplements: (Attach separate page, if needed.)

Name	Dosage	When Taken	What does it treat?

General Health: Food and Medication Allergies: ___

Do you wear medical ID? ☐ Yes ☐ No

Do you have any of these health problems (check all that apply)? Please give details.

High blood pressure: ___ If yes, what is your average BP? ___

Heart disease ___ If yes, explain: ___

High cholesterol ___ If yes, explain: ___

Thyroid disease ___ If yes, explain: ___

Kidney / Bladder problems ___ If yes, explain: ___

Eye / vision problems ___ If yes, explain: ___

Foot problems ___ If yes, explain: ___ Last foot exam / Results ___

Numbness / pain ___ If yes, explain, including location: ___

Balance problems ___ If yes, explain: ___

Frequent Infections ___ If yes, what kind? ___

Sexual function problems ___ If yes, explain: ___

Other medical problems ___ If yes, explain: ___

Last flu vaccine: ___ Last pneumonia vaccine: ___ Last dental exam: ___

Last dilated eye exam / Results ___

Hospitalizations (in the past year or related to diabetes), including dates / reasons ___

Tobacco: ☐ Yes ☐ No Type: ___ # per day: ___ When started: ___

If stopped tobacco use, when did you stop? ___

Recreational Drugs: ☐ No ☐ Yes Explain: ___

How do you rate your health? ☐ Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

Please answer each of the following:

I find it hard to believe that I really have diabetes. ☐ Yes ☐ No

Paying for diabetes care is a problem. ☐ Yes ☐ No

I have difficulty taking care of my diabetes. ☐ Yes ☐ No

I feel unhappy or angry because I have diabetes. ☐ Yes ☐ No

All things considered, I feel satisfied with my life. ☐ Yes ☐ No

Does your culture or religion influence your decisions about diabetes? ☐ Yes ☐ No
(e.g. special foods / fasting or religious observances)

If yes, how? ______________________________

Who is your support person(s) or who helps you? ______________________________

How do you rate the level of stress / tension in your life? ☐ Low ☐ Moderate ☐ High

What causes your stress? ______________________________

How do you manage stress? ______________________________

What worries you most about diabetes? ______________________________

What are you most interested in learning during diabetes education? ______________________________

____

Who will attend class? ______________________________

Participant's Signature: ______________________________ **Date:** ______________

PLEASE DO NOT WRITE BELOW THIS LINE

Educator Assessment Summary: ______________________________

____

____

Education Needs Identified:

☐ All aspects of diabetes education: classes

☐ All aspects of diabetes education: individual sessions: reason: ______________________________

☐ Individual education topics: ______________________________

Refer to plan on education record

Educator Signature: ______________________________ Date: ______________

Educator Printed Name: ______________________________

Point of care: Height __________ Weight __________ BMI __________ B/P __________

Blood glucose __________ Time: __________ (fasting / non-fasting) HbA1c __________