HEALTH SURVEY
General Information

3PA

Name:_____ Date: _____

Birth date: _____ Age:_____ Best phone number_____ Best time to call _____

What is your preferred language? _____ spoken _____ written

Primary Care Doctor:_____ Diabetes Doctor:_____

Diabetes History

When were you diagnosed?_____

How do you feel about having diabetes? _____

Have you ever had diabetes education? ☐ Yes ☐ No When?_____ Where?_____

How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Don't know

Any family members with diabetes? ☐ Yes ☐ No If yes, whom _____

Does anybody help you take care of your diabetes? ☐ Yes ☐ No Whom?_____

Medications

Please list the names of **ALL** medications **(Bring medications to appointment)**

Name	Dosage	When Taken

List Others:

Are you allergic to any medications? ☐ Yes ☐ No List:_____

If you take insulin, do you give your own injections? ☐ Yes ☐ No Explain: _____

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DIABETES PROGRAM
PATIENT SELF ASSESSMENT

PATIENT LABEL

Medical History

What other conditions do you have?

- ☐ Blood pressure problems Explain: _____
- ☐ Kidney problems Explain: _____
- ☐ Heart problems Explain: _____
- ☐ Cholesterol problems Explain: _____
- ☐ Sexual problems Explain: _____

Last eye exam? _____

Last foot exam? _____

Last dental checkup? _____

Do you smoke cigarettes? ☐ Yes ☐ No If yes, number of cigarettes each day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Do you use illicit drugs? ☐ Yes ☐ No If yes, explain _____

Last pneumonia shot? _____ Last flu shot? _____

List major operations you've had: _____

Nutrition

What is your ideal weight? _____

Has your weight changed in the past year? ☐ Yes ☐ No _____ pounds (gained or lost?)

Do you have a history of an eating disorder? ☐ Yes ☐ No (describe) _____

Current diet _____ Who cooks? _____ Who shops? _____

How often do you eat out and where? _____

Do you follow a food plan? Type _____

What changes have you made in your diet recently, if any _____

List any food allergies or intolerances _____

List any cultural / religious diet restrictions you follow, if any _____

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Health Survey
General Information

Diet History (what foods do you usually eat)		
Breakfast	Lunch	Dinner
Snacks:		

Exercise

Have you been advised to limit exercise? ☐ Yes ☐ No (describe) _____

Do you exercise on a regular basis? ☐ Yes ☐ No Type _____

How many times a week do you exercise? _____ For how long? _____ minutes

Pain Assessment

Are you having any pain now? ☐ Yes ☐ No (skip this section)

Where is the pain? _____ Describe _____

Pain Scale: (circle)

0	1	2	3	4	5	6	7	8	9	10
None Annoying		Mild Uncomfortable		Moderate Distressing		Severe Horrible		Very Severe Excruciating		Worst Possible Agonizing

What is your goal? ☐ comfortable ☐ increase function ☐ able to sleep ☐ reduce intensity

Are you under the doctor's care for pain? ☐ Yes ☐ No

Monitoring

What do you consider a normal blood sugar reading? _____

Most recent A1C value _____% Date _____

Do you test your blood sugar? ☐ Yes ☐ No If yes, what meter do you use? _____

How often do you test? ☐ None ☐ 1-2 times day ☐ 3+ times day ☐ Other _____

What time(s) of the day? ☐ breakfast ☐ lunch ☐ dinner ☐ bedtime
☐ 2 hours after meals ☐ other _____

Usual blood sugars? Before meals _____ Two hours after meals _____

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Health Survey

Lows

Have you ever had low blood sugars? ☐ Never ☐ Previously ☐ In the last week

What symptoms did you have? _____

Do you wear a medical identification bracelet or necklace? ☐ Yes ☐ No
Have you ever been unconscious from low blood sugars? ☐ No ☐ Yes When? _____

Can you tell when your blood sugar is too low? ☐ Yes ☐ No

How do you treat a low blood sugar? _____

Highs

Have you ever had high blood sugars? ☐ Yes ☐ No Highest reading _____

Do you test for urine ketones? ☐ Yes ☐ No

Pregnancy

Are you pregnant? ☐ Yes ☐ No Expected due date? _____

Are you planning to become pregnant? ☐ Yes ☐ No ☐ N/A Birth control method? _____

Social History

Describe any stress in your life and how you handle it _____

How do you learn best? ☐ Reading ☐ Demonstration ☐ Hands on ☐ Watching TV

Tell us anything you feel may interfere with your ability to learn: _____

Do you have difficulty with? ☐ Hearing ☐ Speech ☐ Vision Explain: _____

Marital Status: ☐ Single ☐ Married ☐ Significant Other ☐ Divorced ☐ Widowed

(Optional) Race _____ (for data collection purposes only)

Last Grade in School? _____ Number in Household? _____

Do you work? ☐ Yes ☐ No If yes, type of work? _____ Work hours? _____

Is there anything else you would like us to know about you? _____

Your expectations of our Diabetes Program _____

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