PATIENT NAME	DATE OF BIRTH

DIABETES HISTORY

TYPE	HISTORY OF GESTATIONAL DIABETES	WHAT YEAR WERE YOU DIAGNOSED?
☐ Pre-Diabetes ☐ Type 1 ☐ Type 2	☐ No ☐ Yes	

DOES ANYONE IN YOUR FAMILY HAVE DIABETES? ☐ No ☐ Yes	IF YES, WHO?	
DO YOU MONITOR YOUR BLOOD SUGAR AT HOME? ☐ No ☐ Yes	IF YES, HOW OFTEN?	WHAT BRAND MONITOR DO YOU USE?
DO YOU HAVE EPISODES OF LOW BLOOD SUGAR? ARE YOU ABLE TO RECOGNIZE SYMPTOMS OF LOW BLOOD SUGAR? ANY SERIOUS HYPOGLYCEMIC EVENTS? ☐ No ☐ Yes	IF YES, HOW OFTEN?	WHAT TIME OF DAY?
IS YOUR BLOOD SUGAR EVER OVER 250 AT ANY TIME? ☐ No ☐ Yes	IF YES, HOW OFTEN?	WHAT TIME OF DAY?

DIABETES MEDICATIONS AND/OR INSULIN (OR ATTACH COPY)

NAME	DOSE	TIMES TAKEN

OTHER MEDICATIONS--INCLUDE VITAMINS, HERBS AND OTHER SUPPLEMENTS (OR ATTACH COPY)

NAME	DOSE	NAME	DOSE

ALLERGIES TO MEDICATION

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DIABETES SELF-MANAGEMENT TRAINING
PATIENT QUESTIONNAIRE

HEALTH STATUS

GENERAL HEALTH SELF-RATING	HEIGHT	WEIGHT	BLOOD PRESSURE	CURRENT A1C
☐ Excellent ☐ Good ☐ Fair ☐ Poor				

HEALTH HISTORY

(CHECK ALL THAT APPLY)	EXPLANATION (IF NEEDED)
☐ Eye Disease / Vision Changes	
☐ Numbness or Tingling in Extremities	
☐ Kidney Disease	
☐ Foot Problems	
☐ Frequent Infections/Sores that Won't Heal	
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Depression	
☐ Dental Problems	
☐ Other Medical Problems	
☐ Family History of Diabetes	

HEALTH CARE UTILIZATION

DATE OF LAST FOOT EXAM	DO YOU EXAMINE YOUR FEET AT HOME? ☐ No ☐ Yes	IF YES, HOW OFTEN?
DATE OF LAST EYE EXAM	DATE OF LAST DENTAL EXAM	CURRENT BLOOD PRESSURE

EATING HABITS

DO YOU FOLLOW ANY PARTICULAR MEAL PLAN? ☐ No ☐ Yes	IF YES, WHAT IS IT?
WHO PREPARES YOUR MEALS?	DO YOU FOLLOW ANY FOOD RESTRICTIONS? (CHECK ANY THAT APPLY) ☐ Low Salt ☐ Low Carbohydrates ☐ Low Fat ☐ Low Protein

EXERCISE

HOW OFTEN DO YOU EXERCISE?	HOW LONG DO YOU EXERCISE?
WHAT KIND OF EXERCISE DO YOU DO?	

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RISK FACTORS

DO YOU SMOKE?	IF YES, HOW LONG?	NUMBER OF PACKS PER DAY
☐ No ☐ Yes		

HEALTH BELIEF

FEELINGS ABOUT YOUR HEALTH AND DIABETES

PERSONAL HISTORY

NUMBER OF YEARS OF SCHOOL COMPLETED	DO YOU HAVE DIFFICULTIES OBTAINING SUPPLIES OR MEDICATION?
	☐ No ☐ Yes

POSSIBLE BARRIERS TO LEARNING

☐ Visual ☐ Hearing ☐ Language ☐ Other - DESCRIBE: _____

PREFERRED STYLE OF LEARNING

☐ Demonstration ☐ Printed Material ☐ Verbal Explanation ☐ Video /Educ. TV ☐ Power Point Presentation

SUPPORT SYSTEMS

PRIMARY SUPPORT PERSON

CULTURAL FACTORS

DO YOU HAVE ANY LANGUAGE, RELIGIOUS BELIEFS, OR CULTURAL INFLUENCE YOU WOULD LIKE US TO KNOW ABOUT?

☐ No ☐ Yes

WHAT IS YOUR ETHNIC BACKGROUND?

WHICH TOPICS ARE YOU MOST INTERESTED IN? *(Choose all that apply.)*

- ☐ Healthy Eating
- ☐ Physical Activity: Being Active
- ☐ Medications
- ☐ Monitoring
- ☐ Problem Solving: Treating Acute Complications
- ☐ Risk Reduction
- ☐ Healthy Coping
- ☐ Other

PATIENT'S SIGNATURE	DATE

EDUCATOR HAS REVIEWED HISTORY AND DEVELOPED PLAN OF CARE.

EDUCATOR'S SIGNATURE	DATE

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