Beaumont

PRE-DIABETES ASSESSMENT

GENERAL INFORMATION

NAME	DATE
ADDRESS (street, city, zip code)	
BIRTHDATE	AGE
PREFERRED PHONE NUMBER (including area code) ☐ Home ☐ Cell ☐ Work (_____)_____	
EMAIL	
RACE ☐ Black/African American ☐ White ☐ Hispanic ☐ Asian ☐ Native American ☐ Other _____	
MARITAL STATUS ☐ Married ☐ Divorced ☐ Widowed ☐ Single	

How many people live in your home with you? _____

Your occupation _____

Shift normally worked: ☐ Days ☐ Afternoons ☐ Midnights

Highest level of education completed:

☐ Grade school ☐ High school ☐ College ☐ Post-graduate ☐ Other _____

Preferred method of learning: ☐ lecture/discussion ☐ demonstration ☐ reading ☐ film/TV ☐ hands on

Primary language spoken _____ Primary language read_____

Do you have a history of diabetes in your family? ☐ Yes ☐ No If yes, whom? _____

Lab results, indicate result and date:

Blood glucose _____ HbA1c _____

Total Cholesterol _____ Triglycerides _____

LDL Cholesterol_____ HDL Cholesterol _____

Do you have any other medical conditions? Please list _____

_____

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe _____

_____

How would you describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

MONITORING

Do you test your blood glucose? ☐ Yes ☐ No

Name of meter _____ How often?_____

Average results (the range from low to high)_____

Do you keep a record of your results? ☐ Yes ☐ No

NUTRITION HISTORY

Height _____ Weight _____ Goal weight _____

Have you had a recent weight change? ☐ No ☐ Gained ☐ Lost

How much gained or lost? _____ pounds in the past _____ months

Was this expected? ☐ Yes ☐ No

Do you have any of the following problems? ☐ Frequent diarrhea ☐ Constipation ☐ Reflux ☐ Food Allergies

☐ Trouble chewing/swallowing ☐ Other _____

How many average servings do you eat per day of the following:

_____Fruit _____Vegetables _____Whole grains _____Legumes _____Dairy _____Protein/meat

Have you ever followed a special diet? ☐ Yes ☐ No If yes, please describe:_____

_____

How often do you drink alcoholic beverages? ☐ Daily ☐ Weekly ☐ Monthly ☐ Never

Which type? ☐ Wine ☐ Beer ☐ Mixed alcoholic drinks ☐ Other _____

How often do you eat out in restaurants or eat fast food/take out? _____

What type of restaurants _____

Do you skip meals? (check all that apply) ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

List meal and snack times and typical meals including beverages (like milk and juice) that you might have.

Time:_____ Breakfast: _____

_____

Time:_____ Lunch:_____

_____

Time:_____ Dinner:_____

_____

Time:_____ Snacks: _____

_____

Within the last 12 months have you worried that your food would run out before you had the money to buy more

☐ often true ☐ sometimes true ☐ never true

MEDICATIONS

Please list all your medications including over the counter, herbal preparations, vitamins, and other supplements

Medication Name	Dose / Time(s) Taken	Medication Name	Dose / Time(s) Taken

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list:_____

HYPOGLYCEMIC REACTIONS (Low blood glucose reactions)

Have you ever had a low blood sugar reaction? ☐ Yes ☐ No

Describe your symptoms_____

How frequent are your reactions?_____

How do you treat a low blood sugar reactions? _____

EXERCISE

Do you consider yourself: ☐ Active ☐ Sort of active ☐ Not very active

Do you exercise? ☐ Yes ☐ No If yes, please describe below:

TYPE	HOW OFTEN	HOW LONG

Do you carry sugar/food with you when you exercise? ☐ Yes ☐ No

How often do you experience hypoglycemia when you exercise? _____

Is your exercise/activity limited by health problems? ☐ Yes ☐ No

If yes, how? _____

HEALTH HABITS

Do you smoke or use any type of tobacco products? ☐ Yes ☐ No

If yes, how many cigarettes (or other products) each day?_____

Do you use nicotine vaping products? ☐ Yes ☐ No If yes, frequency_____

Do you currently use any recreational drugs? ☐ Yes ☐ No

If yes, what kind? _____ How often?_____

Date of last eye exam:_____ Date of last dental exam:_____

Date of last influenza vaccine:_____ Date of last foot/monofilament exam:_____

What is your typical blood pressure reading?_____

PSYCHOSOCIAL

When you were first told you had pre-diabetes, how did you feel about it? _____

_____

Describe how you feel about it now?_____

_____

Does someone help with your care? ☐ Yes ☐ No

What is the hardest thing for you when dealing with pre-diabetes? _____

_____

What are your goals for pre-diabetes education? _____

_____

Is there anything about your culture/religion that could affect how you manage your pre-diabetes?

☐ Yes ☐ No If yes, describe: _____

What is your living situation today? ☐ I have a steady place to live ☐ I have a place to live today but I am worried about losing it in the future ☐ I do not have a steady place to live.

How hard is it for you to pay for the very basics like food, housing, heating and medical?

☐ very hard ☐ somewhat hard ☐ not at all hard

In the last 12 months, has the lack of transportation kept you from medical appointments, work or for getting things needed for daily living? ☐ Yes ☐ No

Other comments/concerns:_____

_____

_____

Patient Signature: _____ Date:_____

RN/RD Signature: _____ ID#: _____ Date:_____

Time of appointment: _____ Total time: _____