Diabetes Education at Tanner Clinic

Assessment for Type 1, Type 2 and Pre-diabetes

Name: _____Date_____

Diabetes Type:1_____2____ Pre____ Age at diagnosis: _____ Doctor: _____

Age: _____ Male_____Female_____ Height_____ Weight_____

Marital Status: S____M_____W_____D____ Occupation: _____

Have you had previous diabetes education? Yes_____ No_____

Ethnicity: Caucasian____ African/American____ Hispanic____ Native American_____Middle Eastern_____

Asian_____ Other (Specify)_____ Language preference: _____

List blood relatives (living or passed) with diabetes: _____

Other current medical conditions: ision/eyes (specify)_____ kidney _____dental _____

feet _____numbness/tingling in hands or feet_____ high blood pressure _____ high cholesterol _____

Diabetic Keto-Acidosis (DKA)____ depression _____(currently treated?)_____Other:_____

_____

Diabetes Medication(s)/dose(s): _____

Insulin Type and dose(s): _____

Do you take your medications as prescribed, daily? Yes_____No_____

Do you Exercise: yes____no_____if yes, what do you do _____

how many days per week_____how many minutes per day_____

Use of alcohol: Yes___ No___ amount: rare_____occasionaly_____frequently_____

Use of tobacco/nicotine: (including chewing and vaping) Yes___ No___ amount_____quit? When_____

How often do you eat out? _____

Are you allergic to any foods? Yes__No__ What foods_____Reaction_____

Give a sample of when and what you eat at your meals/snacks on a typical day:

Usual time you wake up (get out of bed)_____

Time: _____Breakfast: _____

Time: _____ Lunch: _____

Time: _____Dinner: _____

Time:_____Snack (s):_____

Do you check your blood sugars? yes____ no____ When?_____Glucose monitor brand: _____

Testing times and average results: Fasting_____Other_____

Have you ever had a low blood sugar reaction (hypoglycemia)? Yes____ no____ How often? _____

What are your symptoms? _____

How do you treat the low blood sugar? _____

Last A1C: _____ Date: _____

How do you learn best: listening _____ reading ____ observing _____ doing _____Other_____

Do you have problems with: seeing _____ hearing _____ reading _____ speaking_____
Require any assistive device for normal daily activities: yes ___ no ___ If so, list: _____
Do you have any cultural/religious practices that may affect how you care for your diabetes
yes____ no ____ Describe _____
In your opinion your level of stress is high: agree _____ neutral ____ disagree ____
Do you struggle with making changes in your life to care for your diabetes: agree ____ neutral ____ disagree____
How do you handle stress? _____
What concerns you most about diabetes? _____
_____

Do you do your own meal prep? yes ____ no ____ Food shopping? yes _____ no ____
Are you able to afford nutritious food? yes _____ no _____
Do you have a someone you consider a supporter for you: yes_____not really_____

Check any of the following tests/procedures you have had in the last 12 months:
Dilated eye exam _____ urine test for protein ____ dental exam ____ blood pressure ____
cholesterol ____ A1c____ flu shot _____ pneumonia shot(s) _____Shingles shot_____
foot exam
Do you feel good about your general health: agree _____ neutral _____ disagree _____
Do you feel like diabetes interferes with other aspects of your life: agree ____ neutral____ disagree ____

Women: Previous gestational diabetes? Yes___ No___ Treated with insulin? Yes____ No____
Women of childbearing years: Are you taking Metformin (Glucophage)? Yes_____No____

CLINICIAN ASSESSMENT SUMMARY (to be filled out by Educator)
_____
_____
_____
Education plan: diabetes disease process ____ nutritional management _____ physical activity_____
Using medications_____ monitoring _____ preventing complications _____ behavioral change strategies____
risk reduction strategies _____ psychosocial adjustment _____

Clinician signature: _____ Date: _____
Revised May, 2019