

## 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: vision/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 \_\_\_\_\_ occasionally \_\_\_\_\_ 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