

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