



11. What is your goal for this education session?

- Learn more about diabetes                       Help with meal planning  
 Better blood sugar control                       Weight management  
 Other: \_\_\_\_\_

**Nutrition**

- Height: \_\_\_\_\_ Weight: \_\_\_\_\_ What weight are you comfortable at? \_\_\_\_\_
- Has your weight changed in the past six months?     Yes     No  
 If yes, I've  lost /  gained \_\_\_\_\_ pounds  
 What the weight change intentional? \_\_\_\_\_
- Have you ever received diet counseling?                       Yes     No  
 If yes, describe: \_\_\_\_\_
- How many meals do you eat per day? \_\_\_\_\_ Snacks? \_\_\_\_\_
- How often do you eat/drink:  
 Fruit? \_\_\_\_\_ Juice? \_\_\_\_\_ Milk? \_\_\_\_\_  Fat-free  1%  2%  Whole  
 Vegetables? \_\_\_\_\_ Cheese? \_\_\_\_\_ Sweets? \_\_\_\_\_ Sugar-free desserts? \_\_\_\_\_  
 Beverages with sugar? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Water? \_\_\_\_\_
- Who does the cooking? \_\_\_\_\_ Where do you usually grocery shop? \_\_\_\_\_
- How many times during a week do you eat away from home? \_\_\_\_\_
- How is your food usually prepared?     Fried     Baked     Broiled     Grilled
- How would you describe your portions?     Small     Average     Large
- List any food allergies or intolerances: \_\_\_\_\_  
 \_\_\_\_\_
- Any other special diet needs (health, religious, or cultural): \_\_\_\_\_

**Please indicate what you eat and drink in a typical day. For example, what did you eat today or yesterday? Or attach food records.**

<b>Current Diet History (include amount)</b>		
<b>Breakfast</b> - Time:	<b>Lunch</b> - Time:	<b>Dinner</b> - Time:
<b>Snack</b> - Time:	<b>Snack</b> - Time:	<b>Snack</b> - Time:



3. Have you ever had to be given glucagon? \_\_\_\_\_ Yes \_\_\_\_\_ No
4. Does someone you live with know how to give glucagon? \_\_\_ I don't know \_\_\_ Yes \_\_\_ No  
If yes, do you have a glucagon kit at home? \_\_\_\_\_ Yes \_\_\_\_\_ No
5. What is considered a normal blood sugar range? \_\_\_\_\_

**Chronic Complications**

1. Are you aware of the complications that may develop when you have diabetes? \_\_\_ Yes \_\_\_ No
2. Do you have any of the following complications now? (Check and explain all that may apply.)
- \_\_\_ Eye problems: \_\_\_\_\_
- \_\_\_ Heart problems: \_\_\_\_\_
- \_\_\_ Kidney problems: \_\_\_\_\_
- \_\_\_ GI problems: \_\_\_\_\_
- \_\_\_ Numbness/pain: \_\_\_\_\_
- \_\_\_ Sexual problems: \_\_\_\_\_

**Medical History**

1. When was your last physical examination? \_\_\_\_\_
2. How often do you have your eyes checked? \_\_\_\_\_ Date of last exam: \_\_\_\_\_
3. Do you wear glasses? \_\_\_\_\_ Yes \_\_\_\_\_ No
4. Have you noticed any change in your skin recently? \_\_\_ Yes \_\_\_ No  
If yes, please describe: \_\_\_\_\_
5. How often do you check your feet? \_\_\_\_\_ Date of last exam by MD: \_\_\_\_\_
6. How often do you have a dental checkup? \_\_\_\_\_ Date of last checkup: \_\_\_\_\_
7. How would you describe your general health? \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor
8. Is your health important to you? \_\_\_\_\_ All the time \_\_\_\_\_ Sometimes \_\_\_\_\_ Only when ill \_\_\_\_\_ Not at all
9. Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_
10. Have you been to the emergency room within the last 6 months? \_\_\_ Yes \_\_\_ No  
If yes, describe reason(s): \_\_\_\_\_
11. Do you wear a medical identification bracelet or necklace? \_\_\_\_\_ Yes \_\_\_\_\_ No
12. Have you ever had a shot to prevent pneumonia? \_\_\_\_\_ Yes \_\_\_\_\_ No
13. Have you received a flu shot within the year? \_\_\_\_\_ Yes \_\_\_\_\_ No

14. Have you ever been told you have high cholesterol? Yes \_\_\_\_\_ No \_\_\_\_\_
15. Have you ever been told you have high triglycerides? Yes \_\_\_\_\_ No \_\_\_\_\_
16. Have you ever been told you have high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_

**Stress**

1. Is there much stress in your life? \_\_\_\_\_ Yes \_\_\_\_\_ No  
*If yes, explain:* \_\_\_\_\_
2. What do you do to handle stress in your life? \_\_\_\_\_  
\_\_\_\_\_

**Other**

1. What is your language preference? Spoken: \_\_\_\_\_ Reading: \_\_\_\_\_
2. Do you have trouble:  
Hearing \_\_\_\_\_ Yes \_\_\_\_\_ No; Seeing \_\_\_\_\_ Yes \_\_\_\_\_ No; Reading \_\_\_\_\_ Yes \_\_\_\_\_ No
3. How often do you need to have someone help you when you read instructions, pamphlets, or other written materials from your doctor or pharmacy?  
\_\_\_\_\_Never \_\_\_\_\_Rarely \_\_\_\_\_Sometimes \_\_\_\_\_Often \_\_\_\_\_Always

Patient's name: \_\_\_\_\_ Date: \_\_\_\_\_

***Educational Needs (assessed by the instructor{s})***

Please check all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diabetes disease process | <input type="checkbox"/> Acute complications      | <input type="checkbox"/> Nutritional Management             |
| <input type="checkbox"/> Chronic complications    | <input type="checkbox"/> Physical activity        | <input type="checkbox"/> Goal setting and problem solving   |
| <input type="checkbox"/> Medications              | <input type="checkbox"/> Psychological adjustment | <input type="checkbox"/> Preconception care, Pregnancy, GDM |
| <input type="checkbox"/> Monitoring               |   |   |

Instructor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Instructor Signature: \_\_\_\_\_ Date: \_\_\_\_\_