Guadalupe Regional MEDICAL CENTER
Advanced Medicine. Personal Touch.

Diabetes Education Program

Class Date: _____ Assessment Date: _____

COMMUNITY DIABETES PROGRAM PARTICIPANT INFORMATION SHEET

Name: **Date of Birth:**

Address: **City:** **State:** **Zip Code:**

County: **Email:**

Phone Number Home: **Work:** **Cell:**

Language: ❑ English ❑ Spanish ❑ Other: _____

Present Employment: _____ **Occupation:** _____ **Retired:** ❑ Yes ❑ No

Have you lost any days of work due to diabetes? ❑ Yes ❑ No

Education: ❑ No High School ❑ GED ❑ High School ❑ Associates ❑ Bachelors ❑ Graduate Degree

Do you have: ❑ Visual Problems ❑ Hearing Problems ❑ Reading Problems ❑ Problems with Understanding English

Other problems that may make learning difficult: _____

Do you use a computer to look for health information? ❑ Yes ❑ No

Gender: ❑ Male ❑ Female **Marital Status:** ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Race/Ethnicity: ❑ White ❑ Hispanic ❑ African American ❑ Asian/Pacific Islander ❑ Other: _____

Referring Source: ❑ Physician ❑ Friend/Family ❑ Internet ❑ Flyer ❑ Screening Event _____

Referring Physician: _____ **and/or Clinic/Hospital:** _____

Insurance Provider: ❑ Private Insurance _____ ❑ Medicare ❑ Medicaid ❑ Other Indigent Program
❑ No Insurance

Health History: ❑ Polycystic Ovarian Syndrome ❑ Gestational Diabetes
I have: ❑ Diabetes ❑ Heart Disease ❑ Cancer ❑ High Blood Pressure ❑ Migraines ❑ Seizures ❑ Kidney Disease
❑ Kidney Problems ❑ Sexual Problems ❑ High Cholesterol ❑ Difficulty Seeing ❑ Asthma ❑ Depression ❑ Stroke
❑ Numbness/tingling in feet _____ or hands _____ ❑ Thyroid Disease ❑ Other: _____

What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Pre-diabetes ❑ Don't Know

I have had diabetes for: _____ Months / _____ Years

How do you currently manage your diabetes? Please mark all that apply: ❑ Meal plan ❑ Pills ❑ Exercise ❑ Insulin
❑ Self-blood glucose monitoring ❑ Healthy coping

Do you own a home glucose monitor? ❑ **Yes** ❑ **No** ❑ **Brand:** _____

Testing your blood sugar. How often do you test your blood sugar each day? ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other: _____

When do you test? ❑ Before breakfast ❑ Before lunch ❑ Before dinner ❑ 2 hours after breakfast ❑ 2 hours after lunch
❑ 2 hours after dinner ❑ Other

Attended classes: ❑ Diabetes Class: How long ago? _____ ❑ Weight Control ❑ Glucose Monitoring ❑ Exercise
❑ Dietary Counseling ❑ Smoking Cessation ❑ Other: _____

Check any of the following tests/procedures you have had in the last 12 months:

Foot Exam: ❑ Self or ❑ Healthcare Professional ❑ Dilated Eye Exam ❑ Urine Test for Protein ❑ Dental Exam ❑ HgA1c
❑ Blood Pressure ❑ Weight ❑ Cholesterol ❑ Flu Shot ❑ Pneumonia Shot ❑ Lipid Profile ❑ Cardiac Profile

Do you smoke? ❑ Yes ❑ No **How long have you smoked?** _____ **Number of packs smoked per day** _____

Do you drink alcohol? ❑ Yes ❑ No **How many drinks do you drink a week?** _____

Do you use recreational drugs? ❑ Yes ❑ No **What kind and how often?** _____

What do you think is the most important for you to learn in this class? ❑ Diabetes overview ❑ Medications
❑ Monitoring blood glucose ❑ Meal planning/nutrition ❑ Acute & chronic complications ❑ Physical activity/impact on blood glucose levels
❑ Behavior changes/goal setting ❑ Psychological adjustment

How do you learn best? ❑ Lecture/discussion ❑ Demonstration ❑ Film/TV ❑ Reading ❑ Hands on

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Nutrition

Please describe your daily foods eaten and schedule:

Breakfast: _____ Time: _____ Lunch: _____ Time: _____

Dinner: _____ Time: _____ Snacks/times: _____

Nutritional History

Height: _____ Current weight: _____ What is your goal weight? _____

Have you had recent weight change? ❑ Yes ❑ No ❑ Gained ❑ Lost How much? _____

Was this weight loss or gain expected? ❑ Yes ❑ No

Do you have a history or any of the following problems? ❑ Food allergies ❑ Frequent diarrhea ❑ Constipation ❑ Reflux
❑ Trouble chewing ❑ Eating disorder ❑ Other: _____

Have you ever been on a special diet? ❑ Yes ❑ No If yes, what type? _____

Who cooks? _____ Who grocery shops? _____

Physical Activity

How many times do you exercise per week? _____ times _____ minutes What type of exercise do you do? _____

Is there a particular reason you cannot exercise? If so, list: _____

Medication

Please list all your Medications including over the counter meds or provide a list of your medications

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

How many days out of the week do you remember to take your medication? _____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please describe: _____

Do you wear an insulin pump? ❑ Yes ❑ No

Psychosocial

Which best describes how you feel about diabetes? ❑ Frustrated ❑ Angry ❑ Guilty ❑ Other: _____

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

What health behaviors do you think you need to start changing (ex. Food choices, healthy coping)? _____

Is there anything about your culture/religion that could affect how you manage your diabetes/meal plan? ❑ Yes ❑ No
If yes, please describe: _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Family History: My parent or, grandparent or brother or sister has or had: ❑ Diabetes ❑ Heart Disease ❑ Cancer ❑ High Blood Pressure

Who helps you with your diabetes care? _____

Hypoglycemic Reactions (Low blood sugar reactions)

Have you had any low blood sugars? ❑ Yes ❑ No How often? _____

Can you feel when your blood sugar is low? ❑ No ❑ Yes, my symptoms: _____

Home life: ❑ Living alone or with: _____

Who in your family knows how to treat a low blood sugar reaction? _____

Do you carry "a source of sugar" with you in case of a low blood sugar reaction? ❑ Yes ❑ No

Do you have Glucagon kit at home for severe low blood sugar? ❑ Yes ❑ No ❑ Not sure

Do you carry diabetes identification? ❑ Yes ❑ No

If yes, what kind? ❑ Card ❑ Bracelet ❑ Necklace ❑ Other: _____

What do you consider an acceptable blood glucose reading? _____