HUNTSVILLE HOSPITAL
DIABETES CONTROL CENTER

Patient information sheet

Today's date:					
Patient Name:	**Race:**	**Sex: M ○ F ○**	**Date of birth:**	**Age:**	**Marital status:**
Home Address:	**City:**		**State:**	**Zip:**	**County:**
Home Phone:	**Cell Phone:** **Email address:**				
Social Security No.	**Referring Physician:**		**Primary Care Physician:**		
Employer:	**Status:** *(full-time, part-time, retired, Self-employed)*		**Approximate Date Employed:**		
Address:	**Work Phone:**		**Occupation:**		
Spouse Name:					
Date of Birth:					

Guarantor information ***(if other than person named above)***		
Responsible Party:	*Social Security:*	*Date of Birth:*
Home Address:	*Home Phone:*	*Relation to patient:*
Employer:	*Work Phone:* *Cell Phone:*	
Employer Address:		

Emergency contact			
Name:			
Home Address:	*City:*	*State:*	*Zip:*
Home Phone:	*Work Phone*		

Huntsville Hospital System

Diabetes and Pregnancy Assessment Form

Name:	Age: DOB:	Name of your glucose meter
Referring Physician	Insurance	

Number of people in household: What is your language preference?□English □Other _____Race:_____

Employment:

Stress issues: Financial Issues:

Family Diabetes History: Date of your Diagnosis: Type of diabetes: ☐ Type 1, ☐ Type 2, ☐ Gestational

Siblings with Diabetes: Children with Diabetes: Mother's Family: Father's Family:

Have you had previous gestational diabetes? □yes □no If yes when _____

Have you had any previous diabetes education? □yes □no If yes when/where_____

Pain: [ ] yes [ ] no Location: _____ Intensity: (0-10) _____ Describe _____

Other Medical Conditions: Surgeries:

Allergies _____ Allergic to latex? [ ] yes [ ] no

Health Belief/ Needs/Attitudes: General Health Self Rating: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor

Psych/Social: [ ] Cooperative [ ] Anxious [ ] Crying [ ] Other _____ Cultural/Spiritual needs voiced [ ] yes [ ] no

Neglect/Abuse noted [ ] yes [ ] no Explain _____

Have you wished you were dead or that you could go to sleep and not wake up? □yes □no

Have you actually had any thoughts of killing yourself? □yes □no

Reproductive/Sexual Health: Number of pregnancies_____ Number of live births _____

Did any of your babies weigh 8 lbs? or more at birth ? ☐ Yes ☐ No

Plans to get pregnant in the future: ☐ Yes ☐ No Planning to breast feed? ☐ Yes, ☐ No

Height: Weight: Pre pregnancy weight: Date Due: Weeks of gestation:

Eating Habits: Who cooks? How often do you eat out (x per week)? Where do you eat out most often?

List Special/Religious dietary needs: List Food Allergies/intolerance:

Current diet ordered by MD or diet currently following:

Do you drink alcohol? [ ] yes [ ] no Do you smoke? [ ] yes [ ] no

Exercise Habits: What type? How long? How often?

Please write the times you eat and an idea of the foods you eat and drink in the area below.

BEE Female 665
+ (4.3x_____wt #)
+ (4.7x_____ht.in.)
- (4.7x_____age)
_____x _____a.f.
=

Breakfast Time:	Morning Snack Time:	Lunch Time:	Afternoon Snack Time:	Supper Time:	Before Bed Snack Time:
Please complete medication list on back of this page.					

Patient Label

Patient Signature _____ Date_____

CDE_____ Date _____Time_____

DCCPAS

Ambulatory Summary and Medication Reconciliation List

Patient Label

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MEDHOM

Known Medical Diagnosis/Conditions

Diagnosis/Condition/Visit/Date Onset	Date/Time	Completed By

Known Operative/Invasive Procedures

Operation/Procedure/Date	Date/Time	Completed By

Ambulatory Summary and Medication Reconciliation List

List all Medications including Over the Counter & Herbal
******Use Lay Terms Only******

MEDHOM

Date / Time	Drug	Dose	Route	How Often	Reason	Reviewed/No Change	Weight	Completed by	Information Obtained from/ Reviewed by	Discontinue/ Date
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Latex Allergy: ☐ **Yes** ☐ **No**

Drug/Food/ Environmental Allergies: ☐ **NKA**

Diagnosis _____

Allergy	Reaction

Pregnant ☐ **Yes** ☐ **No**
Lactating ☐ **Yes** ☐ **No**
Renal Dysfunction ☐ **Yes** ☐ **No**
Liver Dysfunction ☐ **Yes** ☐ **No**

Height_____

Patient Label

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