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 Diabetes Control Center
Assessment Form

Date:

Patient's Name:	***Sex: Race:***	***Home Phone: ( )***
Referring Primary Physician:	***Date of birth: Age:***	***Work / Cell Phone: ( )***
Support Systems: Number In Household:	Who is the person you rely on for help:	

What is your education level?: □8th grade or less, □some high school, □ high school diploma, □ some college, □college degree, □any postgraduate

Do you have any of the following? □hearing problems, □vision problems, □poor reading skills, □primary language other than English? □ none

Diabetes History: Siblings with Diabetes:	Children with Diabetes:
Mother's Family:	Father's Family:
Date of your Diabetes diagnosis:	What type? □Type 1 □ Type 2 □ Pre-Diabetes

Have you had diabetes education previously? □ Yes □ No If yes, when and where?

Have you had to go to the hospital in the last 3 months for your blood sugars? □ Yes, □ No Describe why:

Blood Glucose Meter Brand:	When do you test your blood glucose?
Blood glucose range in the last thirty days:	When do you have your highest levels? Lowest levels?

If your blood sugar is too low, what do you do to bring it up to where you want it?

If your blood sugar is too high what do you do to bring it down to where you want it?

Are you ever late or miss checking your blood sugar? [ ] yes [ ] no How often? Do you test your urine or blood for ketones? [ ] yes [ ] no

If you are sick and too ill to eat, what do you change in your usual diabetes management routine?

Medical History: Do you have any of the following? Mark any that apply

□ Vision Problems, □ Numbness, □ Pain, □ Tingling, □ Burning , □ Bloating/Constipation/Diarrhea/Reflux, □ Kidney Disease,
□ Foot Problems, □ Thickened nails, □ Sores, □ Ulcers, □ Swelling, □ Frequent Infections, Urinary Tract, Yeast , Sinus, Other:
□ Vascular Disease, □Circulation Problems, □ Heart Disease, □ Stroke, □ High Blood Pressure, □ High cholesterol, □ High triglycerides
□ Asthma, □ Thyroid Disease, □ Arthritis, □ Other medical conditions: _____
Please list surgeries you have had _____

Please check if you have had these in last 12 months □ urine test for protein □flu shot □pneumonia shot □feet checked by doctor □dental exam □dilated eye exam

Pain: [ ] yes [ ] no Location: _____ Intensity: (0-10) _____ Describe: _____
Pediatric (FACE) _____ Infant (FLACC)_____

Do you have allergies □yes □no If yes list: Are you allergic to latex? □yes □no

Exercise : What type? How long? How often? Date started : Do you wear medical identification?□yes □no

Reproductive/Sexual Health: Experiencing any sexual difficulty? □Yes, □ No Planning to get pregnant in the future: □ Yes □No

Of Pregnancies: # Of Children Born Alive: Birth weight. Greater than 8lbs. □ Yes, □ No
Comments:

Health Belief/Needs/Attitudes: Do you feel good about your general health? □yes □no
Do you have cultural/spiritual needs? □yes □no Explain_____
Neglect/Abuse noted: [ ] yes [ ] no Explain _____

Does diabetes interfere with your life?□yes □no Do you feel you have control over complications of diabetes? □yes □no Do you struggle in making changes to care for diabetes? □yes □no

In regards to your diabetes, what are you most interested in learning about?

What are some of the things that most interfere with your ability to control your diabetes?
What are your feelings about having diabetes?

Do you drink alcohol?: □ Yes, □ No # of drinks/week: Do you use tobacco: □ Yes, □ No # of packs per day:	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

Place patient label in this box

_____
Certified Diabetes Educator/Date/Time

DCCAST

Ambulatory Summary and Medication Reconciliation List

Patient Label

HUNTSVILLE HOSPITAL
DIABETES CONTROL CENTER

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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