Huntsville Hospital Diabetes Control Center Type 1 and Type 2 Assessment Form

Name: _____ Age: _____ D.O.B._____ Preferred Language □English _____

Do you have a pacemaker or other implants? □ yes □ no_____

Preferred way to communicate: □ verbal □ written □ other_ _____

Do you use any of the following □ contacts □ eye glasses □ hearing aids □other _____

How would you rate your reading skills? □ good □ fair □ poor

Diabetes: □ type 1 □ type 2 Date of your diabetes diagnosis_____

Have you been hospitalized in the past 3 months regarding blood glucose? □ yes □ no_____

Do you have a working blood glucose meter? □ yes □ no Glucose meter name_____

Do you test your blood glucose? □ yes □ no Blood glucose range in past 30 days_____

How often do you check blood glucose? □ 1time/day □ 2 or more times/day □ 1 or more time/week □ occasionally

When do you check your blood glucose? □ before breakfast □ before lunch/dinner □ 2 hours after meals □ before bedtime

What is your blood glucose target range? _____ □ Do not know

If you blood glucose is too high, what do you do to bring it down?_____

Do you check your urine or blood for ketones □ yes □ no Number of lows in past month_____

How do you treat your low blood glucose reactions?_____

If you get sick, do you do anything different for your diabetes? □ yes □ no_____ _____

Previous diabetes education: Location _____Date:_____ Reason:_____

Number in your household _____How are they related to you? _____Who do you rely on?_____

Highest education level: □ grade school □ highschool □ some college □ bachelors □ post graduate □ skills trade □ other_____

Check any done in past year: □ urine test for protein □ feet checked by doctor □ dental exam □ dilated eye exam

Have you had the seasonal flu vaccine? □ yes □ no pneumonia vaccine ? □ yes □ no

Do you have cultural, religious beliefs that affect how care for your health? □ yes □ no _____

What are you most interested in learning about regarding diabetes?_ _____

Do you feel good about your general health? □ yes □ no _____

Do you feel diabetes interferes with your life? □ yes □ no_____

Do you feel you have control over diabetes complications? □ yes □ no_____

Do you struggle to make changes? □ yes □ no_____

What obstacles do you have in manage diabetes? _____

What word best describes how you feel about having diabetes? □ fear □ denial □ anger □ overwhelmed □ acceptance

Patient Label

DCCAST

Exercise habits: What type? _____ How long?_____ Times per week_____

What is your occupation?_____ Days of week you work _____ Shift_____

Employment issues_____ Home Issues_____ Other stress issues_____

Previous diets_____ Who does food shopping? _____Who cooks? _____

Number of times you eat out per week _____Places you eat out most often_____

Do you have cultural, religious or spiritual beliefs that affect how you eat or care for your health? _____

In the boxes below, please write the times you eat and and list of what you eat and drink for meals/snacks

Breakfast Time:	Snack Time:	Lunch Time:	Snack Time:	Supper Time:	Before Bed Snack Time:

Has your weight □ increased □ decreased □ remained same in the past 6 months?

What is the most you have ever weighed? _____

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

Is your pain being managed by your doctor? □ yes □ no Comment:_____

Please check any of these 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 □ Vascular Disease, □ Circulation Problems, □ Heart Disease,
□ Stroke □ High Blood Pressure, □ High cholesterol, □ High triglycerides
□ Asthma □ Thyroid Disease □ Arthritis □ Sexual difficulties
□ Other Medical Conditions_____

Please list surgeries or procedures you have had:

_____

Do you use tobacco? □ yes □ no # packs per day_____

Do you drink alcohol? □ yes □ no # drinks per week_____

Do you feel safe at home? □ yes □ no_____

Do any of your family members have diabetes? If yes, who? _____

How many times have you been pregnant? _____ Number of children born alive_____ Birth weight greater than 8 lb □ yes □ no

Patient Label

DCCAST

HUNTSVILLE HOSPITAL

DIABETES CONTROL CENTER

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