5B1 DIABETIC RECORD

St. Vincent Diabetes Center
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

Patient ID _____

# ADULT ASSESSMENT HEALTH PROFILE

## *GENERAL INFORMATION:*

Name:_____ Date of Birth: _____
First / Middle / Last

Current Occupation: _____ ☐ Retired

Height_____inches (____cm) Weight_____pounds ( ____kg) Usual Weight_____

Diagnosis: ☐ Type 2 ☐ Type 1 ☐ Pre-diabetes ☐ Polycystic Ovary Syndrome (PCOS) ☐ I don't know

Date of Diagnosis?_____

## *EDUCATIONAL NEEDS:*

In your own words, what is diabetes? _____

Have you ever had diabetes education before? ☐ No ☐ Yes
Where?_____ When? _____

How interested are you in learning about how to manage your diabetes?
☐ Not interested ☐ Slightly interested ☐ Fairly interested ☐ Extremely interested

What would you like to learn about while you are at the Diabetes Center? *Mark all that apply.*
☐ Activity ☐ Medication ☐ Diabetes disease process ☐ Reducing risk of diabetes complications
☐ Eating ☐ Checking blood sugar ☐ Lifestyle changes ☐ Adjusting to diabetes diagnosis

How do you learn best? *Mark all that apply.*
☐ Reading ☐ Practicing ☐ Talking ☐ Watching ☐ Listening ☐ Other _____

Level of education completed:
☐ Grade School ☐ Junior High ☐ High School/GED ☐ Trade School ☐ College ☐ Masters
☐ Doctorate ☐ Other _____

Mark any of the following which may influence your ability to learn:
☐ Cannot read ☐ Difficulty seeing ☐ Too weak ☐ Inability to concentrate ☐ None
☐ Cannot write ☐ High stress level ☐ Memory lapses ☐ Pain
☐ Difficulty hearing ☐ Too ill ☐ Learning disability: _____

☐ Other_____

How often do you need help understanding written instructions, pamphlets or other materials from your doctor or pharmacist? ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

Primary language spoken: ☐ English ☐ Spanish Other: _____
Do you read and understand English? ☐ No ☐ Yes
What written language do you prefer for learning? _____
What spoken language do you prefer for learning? _____

## *SOCIAL HISTORY:*

Describe your living situation:
☐ I live alone ☐ I live with family/significant others ☐ I live in an assisted living/retirement facility

Do you have religious or cultural practices that influence your healthcare or food choices? ☐ No ☐ Yes
*If yes, describe:*_____

5B1 DIABETIC RECORD

St. Vincent Diabetes Center
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

Patient ID

# ADULT ASSESSMENT HEALTH PROFILE

***MEDICAL HISTORY:***

Do you have any food, drug or latex allergies? ☐ No ☐ Yes List: _____

_____

Do you have problems with: *Mark all that apply*
☐ Use of hands ☐ Use of legs/feet ☐ Frequent falls ☐ Balance ☐ None

Do you use a mobility aid? ☐ No ☐ Yes *If yes, mark all that apply.*
☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Do you have you any other health problems? *Mark all that apply.*

☐ Stroke
☐ Eye problems
☐ Chewing/Swallowing problems
☐ Thyroid Disease
☐ Heart Failure
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Shortness of Breath
☐ Asthma
☐ COPD/ Emphysema
☐ Kidney/Bladder problems
☐ Stomach/Bowel problems
☐ Numbness/Tingling/Pain of hands/feet
☐ Other foot problems
☐ Sexual Function problems
☐ Sleep problems
☐ Mental/Emotional problems
☐ Eating Disorder
☐ Surgery in past year
☐ None

☐ Other: _____

_____

**WOMEN'S HEALTH:**
☐ Irregular periods ☐ Infertility ☐ Tubal Ligation ☐ Menopausal ☐ Post Menopausal ☐ Hysterectomy

Planning pregnancy? ☐ No ☐ Yes Preventing pregnancy? ☐ No ☐ Yes
Are you pregnant now? ☐ No ☐ Yes If yes, number of weeks pregnant: _____ weeks
Prepregnancy weight: _____ pounds _____ (kg)

Have you received education about controlling blood sugar before and during pregnancy? ☐ No ☐ Yes

Are you currently having pain? ☐ No ☐ Yes *If Yes, rate your pain:*

| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| No Pain | | | | | Moderate Pain | | | | | Worst Possible Pain |

Do you currently smoke cigarettes, cigars or use tobacco? ☐ No ☐ Yes

Do you ever drink alcohol? ☐ No ☐ Yes Do you use recreational drugs? ☐ No ☐ Yes

***MEDICATION HISTORY:***

List the kind and amount of **DIABETES** medications you currently take and when you take them:

| Name of Medicine | Dose | Time Medicine Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

How often do you MISS or SKIP a dose of your diabetes medicine?
☐ Daily ☐ Several times per week ☐ A few times per month ☐ Once in a while ☐ Never

5B1 DIABETIC RECORD

*St.Vincent Diabetes Center*
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

*Patient ID* _____

# ADULT ASSESSMENT HEALTH PROFILE

**Complete this section if you inject insulin or other injectable diabetes medications:**

Where are injections given?
☐ Back of upper arms ☐ Thigh ☐ Abdomen/Stomach ☐ Buttocks ☐ Other: _____

How is the injection given?
☐ Syringe ☐ Pen device Do you prime the pen device? ☐ No ☐ Yes

Who generally gives the injection?
☐ Self ☐ Other:_____

How do you store insulin/other injectable diabetes medicine you are **currently using**? _____

How do you store insulin/other injectable diabetes medicine **currently not in use**? _____

Are you having any problems with injections? ☐ No ☐ Yes
If yes, describe:_____

Do you use an insulin pump? ☐ No ☐ Yes Name and Model of pump:_____

Length of time on pump therapy?_____ Where did you receive your pump training?_____

_____

List **ALL** other prescribed / over-the-counter medications and supplements you take.

| Name of drug | Amount Taken and When | Reason Drug is Taken |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

***BLOOD SUGAR MONITORING:***

Do you use a meter to check your blood sugar? ☐ No ☐ Yes Name of meter: _____

How do you dispose of sharps/needles? _____

How often do you usually check your blood sugar?
☐ 4 or more times a day ☐ 3 times a day ☐ 2 times a day
☐ Once a day ☐ Once a week or less ☐ Never

What is your usual blood sugar range before meals? _____ to _____ after meals? _____to _____

What level do you consider too high?
☐ I don't know ☐ Over 110 ☐ Over 140 ☐ Over 180 ☐ Over 200 ☐ Over 250

How often do you have high blood sugar?
☐ Daily ☐ Several times a week ☐ Few times a month ☐ Rarely ☐ Never ☐ Don't know ☐ Not applicable

When your blood sugar is too high, what do you usually do? *Mark all that apply.*
☐ Change diet ☐ Change exercise ☐ Test ketones
☐ Check meter/strips ☐ Call my health care provider ☐ Not applicable
☐ Do nothing ☐ Increase diabetes mediation
☐ Other_____

5B1 DIABETIC RECORD

St. Vincent Diabetes Center
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

Patient ID

# ADULT ASSESSMENT HEALTH PROFILE

What level do you consider too low?
☐ I don't know ☐ Under 150 ☐ Under 100 ☐ Under 80 ☐ Under 70 ☐ Under 50

How often do you have low blood sugar?
☐ Daily ☐ Several times a week ☐ Few times a month ☐ Rarely ☐ Never ☐ Don't know ☐ Not applicable

When you think your blood sugar is low, what do you do? *Mark all that apply.*
☐ Eat/Drink _____ ☐ Stop exercise ☐ Reduce diabetes medication
☐ Call my Health Care Provider ☐ Check blood sugar ☐ Do nothing
☐ Other: _____

When your blood sugar is low, how often are you able to get it where you want it within 30 minutes?
☐ Every time ☐ Most times ☐ Sometimes ☐ Never

***NUTRITION:***

What is your goal weight? _____ pounds

How would you describe your weight history?
☐ My weight has been stable for several years
☐ My weight has changed:
☐ Gained ☐ Lost Time span of weight change: _____
Reason for weight change: ☐ Diet and exercise ☐ Related to being ill ☐ Unexplained

Do you have any diet restrictions? ☐ No ☐ Yes
*If yes, explain:*_____

Are there any foods you avoid? ☐ No ☐ Yes *If yes please list them:*
_____

| **Regular Schedule** | | **Day off or Alternate Schedule** | |
|---|---|---|---|
| Wake-up | am/pm | Wake-up | am/pm |
| Breakfast | am/pm | Breakfast | am/pm |
| Work start time | am/pm | Work start time | am/pm |
| Lunch | am/pm | Lunch | am/pm |
| Work End Time | am/pm | Work End Time | am/pm |
| Dinner time | am/pm | Dinner time | am/pm |
| Bedtime | am/pm | Bedtime | am/pm |

Have you made any diet changes since diagnosis? ☐ No ☐ Yes *If yes, explain:*_____
_____

When do you eat snacks? *Mark all that apply.*
☐ Mid-morning ☐ Mid-afternoon ☐ Before Bedtime ☐ Snack throughout the day ☐ Seldom snack

How often do you skip meals?
☐ Never skip meals ☐ 1-2 meals per week ☐ 3-5 meals per week ☐ At least 1 meal per day

How often do you eat away from home?
☐ Less than once per week ☐ 1-2 times each week ☐ 3-5 times each week ☐ Daily

When you eat away from home, where do you eat?
☐ Fast Food ☐ Sit down restaurants ☐ Cafeterias ☐ Buffets ☐ Vending machines ☐ Other _____

Who grocery shops?
☐ Myself ☐ My spouse ☐ Other: _____

Who most often prepares your food?
☐ Myself ☐ My spouse ☐ Other: _____

What makes it hard to eat healthy? _____

5B1 DIABETIC RECORD

St. Vincent Diabetes Center
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

Patient ID

# ADULT ASSESSMENT HEALTH PROFILE

***EXERCISE/PHYSICAL ACTIVITY***:

How would you describe your level of physical activity?

☐ Very active (*exercise daily, keep active most of the day at work and home)*
☐ Moderately active (*exercise 2-4 days per week, fairly active several hours every day*)
☐ Sedentary (*sit several hours each day. Exercise 0-2 times per week*)
☐ Inactive (*sit most hours of the day, rarely exercise*)

Is it OK with your doctor if you exercise? ☐ No ☐ Yes ☐ I don't know

During a usual week, how many days do you exercise?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

How many minutes do you usually exercise?

☐ 1-15 ☐ 16-30 ☐ 31-45 ☐ 45-60 ☐ More than an hour

Where do you exercise? _____

What makes it hard to exercise? _____

_____

***SICK DAYS:***

What do you do when you are sick? *Mark all that apply*

☐ Replace usual food with carbohydrates or sugar
☐ Take diabetes medications
☐ Check blood sugar more often
☐ Do nothing
☐ Other: _____
☐ Drink more water
☐ Check ketone levels
☐ Contact health care provider
☐ I don't know

Number of emergency room visits or hospital admissions for diabetes within the last 6 months: _____

Number of days missed from work, school or usual routine because of diabetes within the last 6 months:____

***HEALTH SERVICES:***

In the PAST YEAR have you had the following services to prevent problems?

| | | | |
|---|---|---|---|
| Met with Diabetes Educator | ☐ No | ☐ Yes | |
| Met with Registered Dietitian | ☐ No | ☐ Yes | |
| Eye exam by an eye doctor | ☐ No | ☐ Yes | |
| Complete physical with lab tests | ☐ No | ☐ Yes | |
| Cholesterol test | ☐ No | ☐ Yes | ☐ Don't Know |
| Urine test for protein | ☐ No | ☐ Yes | ☐ Don't Know |
| Flu vaccine | ☐ No | ☐ Yes | |

In the PAST 6 MONTHS have you had the following services to prevent problems?

| | | | |
|---|---|---|---|
| Saw a health care provider (doctor, nurse practitioner, physician's assistant) | ☐ No | ☐ Yes | |
| Foot exam by a health care provider | ☐ No | ☐ Yes | |
| Blood pressure check | ☐ No | ☐ Yes | |
| A1c test _____% Date: _____ | ☐ No | ☐ Yes | ☐ Don't Know |
| Dental exam and cleaning | ☐ No | ☐ Yes | |
| Have you ever had a pneumonia vaccine? | ☐ No | ☐ Yes | ☐ Don't Know |

How often do you check your feet with your socks off?

☐ Daily ☐ Several times a week ☐ A few times a month ☐ Once in a while ☐ Never

Do you wear a bracelet or keep something with you to identify that you have diabetes? ☐ No ☐ Yes

5B1 DIABETIC RECORD

St. Vincent Diabetes Center
8220 Naab Road, Suite 102 • Indianapolis, IN 46260
Phone: (317) 338-2349 • Fax: (317) 338-2797

Patient ID

# ADULT ASSESSMENT HEALTH PROFILE

***LIVING WITH DIABETES:***

My level of stress is high: ☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know

How do you deal with stress? *Examples: talking, smoking, eating, meditation, prayer, exercise etc.*

_____

I have good support to control my diabetes: ☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know
From whom? ☐ Family ☐ Friends ☐ Co-workers ☐ Healthcare Provider ☐ Others

I feel good about my general health: ☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know

My diabetes interferes with other aspects of my life: ☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know

I have some control over whether or not I get diabetes complications ☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know

What concerns you most about your diabetes? _____

_____

What is hardest for you in caring for your diabetes?_____

_____

What are your thoughts or feelings about this issue? *Example: frustrated, angry* _____

_____

***MAKING CHANGES:***

Having diabetes means you may need to make changes. What changes, if any, would you like to make now? *Mark all that apply.*

☐ Exercise
☐ Checking blood sugar
☐ Living with diabetes
☐ None of the above
☐ Healthy eating
☐ Taking medication
☐ Quit smoking
☐ Reduce risks of diabetes complications
☐ Problem solving for blood sugars and sick days
☐ I do not know what to change

I struggle with making changes in my life to care for my diabetes:
☐ Agree ☐ Neutral ☐ Disagree ☐ I don't know

What makes it hard to make the changes you want? *Mark all that apply.*

☐ I don't know what to do or how to do it.
☐ I can't see well enough to do it.
☐ My family /friends do not support me
☐ It's too hard.
☐ It's not that important.
☐ My health is not good.
☐ I don't have the time
☐ I can't afford it
☐ No place to do it.
☐ I don't enjoy it.
☐ I don't have the will power
☐ I can't remember to do it.
☐ It's too uncomfortable.
☐ None of these
☐ Other: _____

Signature: _____

Relationship to patient: _____

Date:_____

**FOR OFFICE USE ONLY**

*Instructor Signature* _____ *Date:*_____

*Instructor Signature* _____ *Date:*_____

*Instructor Signature* _____ *Date:*_____

*Instructor Signature* _____ *Date:*_____