Diabetes Learning Center
Edward - Elmhurst Health
Center for Health 1200 S. York St., Elmhurst, IL
Diabetes Assessment

Name_____ Age_____ Sex_____ Phone _____ Date: _____

Marital Status: M S W D Date of Birth: _____ Referring Physician_____

Primary Support Person (s) _____Relationship _____

Ethnicity _____

Last Grade of Education Completed _____

Are you currently working? Yes____ No_____ Occupation: _____

When were you first told you had diabetes? (month/year) _____

Preferred pharmacy _____

HEALTH HISTORY/RISK FACTORS

- Have you ever attended any diabetes education classes: Yes _____ No _____
  If so, where did you attend classes? _____
- Are you testing your blood sugar at home? Yes _____ No _____
  If yes: How many times each day? _____ Name of meter: _____
- What are your blood sugar ranges?

  Before Breakfast _____ Bedtime _____
  Before Dinner _____ Other _____
- Do you have low blood sugar reactions? Yes ____ No ____ If yes, how many times per month? _____
- When do they occur? Morning_____ Afternoon_____ Evening_____ Overnight_____
- How do you treat your low blood sugar? Glucose tabs_____ Gel_____ Other_____

- When was your last dilated eye exam? _____
- Has your provider performed a sensitivity test on your feet? Yes _____ No _____
- Do you smoke cigarettes, vape, use marijuana or CBD? Yes ____ No ____
- Do you receive the flu vaccine yearly? Yes____ No _____

- Do you exercise regularly? Type _____ # Minutes _____ Frequency _____
  If you are not exercising, what is preventing you? _____
- Do you get enough rest/sleep at night? Yes_____ No _____
- Do you feel that you have a good outlet or way to manage stress? Yes No

- Please write agree, disagree or unsure in response to the following: I have control over whether I develop complications related to diabetes? _____
- Do you have any difficulty affording your current medications? Yes _____ No _____
- Do you have any cultural or religious preferences that may influence how you care for your diabetes? Yes _____ No _____

NUTRITION HISTORY

- Has your weight changed in the past six months? lbs. gained _____ lbs. lost _____
- Have you ever had any diet instruction for diabetes? Yes _____ No _____
  If yes, when _____ By whom _____
  Were you able to follow the plan? Yes____ No____ If no, why _____
- Is there anything wrong with the way you eat? Yes____ No____
  If yes, please explain _____
  Will it be difficult to make healthy food choices? Yes____ No____ Why _____
- Do you follow any special diet?
  Low calorie ____ Low fat ____ High fiber ____ Other (specify) _____
  Low salt ____ Low protein ____ Vegetarian ____
- Do you eat any meals away from home? (Fast food, carry out, delivery, brown bag, cafeteria, sit down restaurant). How often:
  Breakfast _____x weekly Breakfast _____x weekly
  Lunch _____x weekly Lunch _____x weekly
  Dinner _____x weekly Dinner _____x weekly
- How many times in one week do you eat the following food?
  Regular pop or sugary drinks _____ Candy bars/pieces _____ Pies/cakes _____
  Fruit juice _____ Ice cream, puddings _____ Sweet rolls/pastries _____
  Hard Candy _____ Cookies _____ Other sweets _____

LEARNING NEEDS

- How do you best learn? (Place check mark by item) ___ Hearing ____ Reading ___ Observing ____ Doing
- What are you most interested in learning from diabetes education sessions?
  Improved eating habits ____ Test blood sugar more often _____ Avoid low blood sugar reactions ____
  Increased exercise _____ Lose weight _____ I do not want to make any changes ___
  Reduce stress _____ Lower cholesterol _____

How do you feel about having diabetes? _____