

*place label here*

Name: \_\_\_\_\_  
 UIN: \_\_\_\_\_  
 Date: \_\_\_\_\_

### Diabetes History Form

#### General Information

1. Education Major \_\_\_\_\_ Expected Graduation \_\_\_\_\_
2. Marital Status    Single    Married    Other \_\_\_\_\_
3. How many people live in your household? \_\_\_\_\_
4. Is there anyone who will help you in your diabetes care?    Yes    No    If yes, who \_\_\_\_\_
5. Do you work outside of taking classes?    Yes    No    Where \_\_\_\_\_ Hours/week \_\_\_\_\_
6. Diabetes provider at home \_\_\_\_\_ Phone \_\_\_\_\_

#### Diabetes History

1. How long have you had diabetes? \_\_\_\_\_ What type?    Type 1    Type 2    Gestational    Unknown
2. List any family members with diabetes \_\_\_\_\_
3. How would you rate your understanding of diabetes?    Good    Fair    Poor
4. What areas of diabetes would you like to learn more about?  
Diet    Stress    Blood testing    Low blood sugar    Insulin pumps    Pills for diabetes  
Exercise    Sick days    Complications    High blood sugar    Pregnancy and diabetes
5. How do you learn best?    Written material    Verbal discussion    Hands on
6. What is your goal for this session?    Learn more about diabetes    Help with meal planning  
Better blood sugar control    Weight management

#### Nutrition

1. Has your weight changed in the last 3 months?    Yes    No    **I have** Gained    Lost \_\_\_\_\_ lbs.  
 Was this weight change intentional?    Yes    No
2. How many times do you eat per day?    Meals \_\_\_\_\_    Snacks \_\_\_\_\_
3. How often do you eat/drink the following? (per week)  
      \_\_\_\_\_Fruits    \_\_\_\_\_Vegetables    \_\_\_\_\_Sweets    \_\_\_\_\_Fast Food    \_\_\_\_\_Milk (fat free,  
      \_\_\_\_\_Juices    \_\_\_\_\_Cheese    \_\_\_\_\_Alcohol    \_\_\_\_\_Water    1%, 2%, whole)
4. How often per week do you eat away from home? \_\_\_\_\_ Where \_\_\_\_\_
5. How is your food prepared?    Fried    Baked    Broiled    Grilled
6. How would you describe your portions? Small    Average    Large
7. Any special diet needs or practices? \_\_\_\_\_
8. Have you ever been told you have    High cholesterol    High triglycerides    High blood pressure
9. What diet plan do you typically follow? Carb counting    Calories a day    Other \_\_\_\_\_
10. How is your insulin dosage calculated? N/A    \_\_\_\_\_ Carbs to \_\_\_\_\_ units insulin (type \_\_\_\_\_)  
Fixed dose per meal \_\_\_\_\_ (type \_\_\_\_\_)  
Adjustable dose dependent on blood glucose.

11. Complete the food history table below including amount and how typically prepared

Breakfast	Lunch	Dinner
Snack	Snack	Snack

*place label here*

Name: \_\_\_\_\_

UIN: \_\_\_\_\_

Date: \_\_\_\_\_

**Medication**

- If you take insulin: (if no skip to 6)  
Do you use?  A syringe  Insulin pen  Insulin pump  Insulin inhaler
- What injection sites are used? \_\_\_\_\_
- Where do you keep your insulin? \_\_\_\_\_
- Do you reuse your syringes?  Yes  No How many times before disposal? \_\_\_\_\_
- How/where do you dispose of your syringes? \_\_\_\_\_
- Do you use pills for your diabetes medication?  Yes  No If yes, list amount and frequency below:  
\_\_\_\_\_

**Monitoring**

- Do you test your urine: For **sugar**?  Yes  No For **ketones**?  Yes  No How often \_\_\_\_\_
- Do you test your blood sugar?  Yes  No How often? \_\_\_\_\_ Typical results \_\_\_\_\_
- Do you keep a record of you results?  Yes  No

**Exercise**

- Do you exercise regularly?  Yes  No What type? \_\_\_\_\_  
How often? \_\_\_\_\_ For how long? \_\_\_\_\_
- List any problems you have with exercise: \_\_\_\_\_

**Complications**

- If you have ever had a low blood sugar reaction? How did you feel? \_\_\_\_\_  
How did you treat it? \_\_\_\_\_ How often has this occurred? \_\_\_\_\_
- Do you carry a source of sugar with you?  Yes  No
- Have you ever had to be given glucagons?  Yes  No
- If you have ever had High blood sugar: How did you feel? \_\_\_\_\_  
How did you treat it? \_\_\_\_\_ How often has this occurred? \_\_\_\_\_
- What is your daily blood sugar normal range? \_\_\_\_\_
- Are you aware of the long term complications of Diabetes?  Yes  No
- Do you have any of the following?  Eye problems  Heart problems  Kidney problems  
 Numbness/pain  Sexual problems  Dental problems

Please Explain \_\_\_\_\_

**Medical History**

- When was your last: **Physical?** \_\_\_\_\_ **Eye exam?** \_\_\_\_\_ **Dental exam?** \_\_\_\_\_
- Do you smoke?  Yes  No If yes, how much? \_\_\_\_\_ For how many years? \_\_\_\_\_
- Do you drink alcohol?  Yes  No If yes, how much? \_\_\_\_\_
- Have you ever been hospitalized with diabetes?  Yes  No Number of times \_\_\_\_\_
- Have you been in the emergency department because of your diabetes?  Yes  No How many times \_\_\_\_\_
- Do you wear a medical identification bracelet or necklace?  Yes  No
- Have you ever had a Pneumonia vaccination?  Yes  No When? \_\_\_\_\_
- Have you received a Flu shot within the year?  Yes  No

**Other**

Please list any other information that you feel would be important for your provider to know that would assist them in treating you: \_\_\_\_\_

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_