Mary Washington Hospital

MWHC

Thank you for choosing Mary Washington Hospital Diabetes Self-Management Education and Support Services located in the MWHC Medical Pavilion at Cosner's Corner Office Park, 4710 Spotsylvania Parkway, Suite 200, Fredericksburg, VA 22407.

Please arrive 10 minutes prior to your scheduled time if you are unable to fill out your Health History form prior to your appointment.

*We request a minimum of 24-hour notice if you must cancel or reschedule your appointment. Failure to provide 24-hour notice may result in a no-show fee.

As a courtesy, Mary Washington Hospital will bill your insurance company for your diabetes education.

We request that you:

- Bring your completed Health History form (on pages 3–4 of this packet).
- Be prepared to show your insurance card.
- Bring your blood sugar meter and logbook if you currently are checking your blood sugars. You do not need to buy a meter if you do not already have one. We will assist you with that process.
- Please feel free to bring a guest (spouse, friend, family member).
- Remember there is no need to fast before this appointment.

Our health care team of diabetes experts is committed to helping you and your family develop the skills, knowledge, and confidence to control diabetes. Mary Washington Hospital Diabetes Self-Management Education and Support Services has earned the American Diabetes Association Recognition for quality patient education.

If you have any questions, please feel free to contact us at 540.741.2210.

Daniell McKiver
Operations Manager

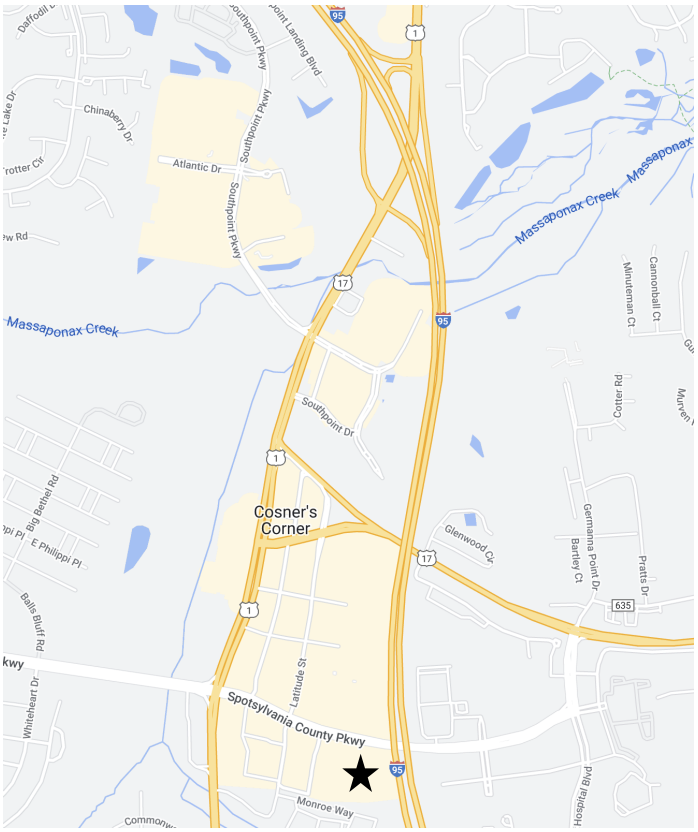
Our educators:
Stefanie Rekdal, RD, CDCES, CPT
Jody Long, MS, RD, CDCES
Parminder Singh, BSN, RN, CDCES
Courtney Wilkerson, BSN, RN, CDCES
Sarah Whitson, BS, RD
Elsa Nicholson, BS, RD

Directions to:
Diabetes Management

4710 Spotsylvania Parkway, Suite 200
Fredericksburg, VA, 22407
540.741.2210

From Interstate 95 South, take exit 126-Spotsylvania, Turn right onto Route 1 South. Go approximately 1 mile. Turn left unto Spotsylvania Parkway (there will be a CVS on your right-hand side). Go approximately 0.4 mile. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2nd floor, turning right and right again after elevator
From Interstate 95 North, take exit 126 B onto Rt 1 South. Follow directions listed above.

From Rt VA 2/US 17 (New Post) Take US 17 N towards Rt 1, drive 5 miles. Turn left onto Hospital Boulevard, drive 0.2 miles. Turn right onto Spotsylvania Parkway. Cross over I-95 and make a U-turn. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2nd floor, turning right and right again after elevator.



Scan me with your phone camera for Google maps directions.

Name:	Cell Phone:	Sex: □ Male □ Female
Occupation:	Marital Status: □ S □ M □ W □ D	Gender:

Name of Referring Physician:	Name of Family Physician:
Are you allergic to any **sulfa** medications? □ Yes □ No □ Unknown	Do you have any diagnosed **food** allergies? □ No □ If Yes, please list:

Are you aware of the **complications** that may develop when you have diabetes? □ Yes □ No
What **type** of Diabetes do you have? □ Type 1 □ Type 2 □ Gestational □ Unsure
When and how were you **diagnosed** with Diabetes? _____

PLEASE MARK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Thyroid Disease	□ Yes	□ No	
Heart Disease	□ Yes	□ No	
High Blood Pressure	□ Yes	□ No	
High Cholesterol/Triglycerides	□ Yes	□ No	
Eye/Vision problems	□ Yes	□ No	Date of last **eye exam**: _____
Kidney problems	□ Yes	□ No	
Bladder problems	□ Yes	□ No	
Dental/Mouth problems	□ Yes	□ No	Date of last **dental exam**: _____
Liver disease	□ Yes	□ No	
Foot problems	□ Yes	□ No	
Do you check your feet daily?	□ Yes	□ No	Date of last **foot exam** (by physician):_____
Circulation problems	□ Yes	□ No	
Numbness or pain in hands, feet, or legs	□ Yes	□ No	
Difficulty with sexual function	□ Yes	□ No	
Gastroparesis	□ Yes	□ No	
Stroke	□ Yes	□ No	
Depression	□ Yes	□ No	Treatment: _____
Have you ever been told you have sleep apnea?	□ Yes	□ No	
If yes, do you use a CPAP/BiPAP machine?	□ Yes	□ No	
If female, do you use contraception?	□ Yes	□ No	

Please list any **other illnesses** not mentioned above: _____

_____

Please list any significant **surgical history**: _____

_____

HAVE YOU EXPERIENCED:

Low blood sugar (70 or below)? □ Yes □ No
Hospitalization for your diabetes? □ Yes □ No

Name and Dose of **Diabetes** Medication(s): □ N/A		Side Effects	
Do you **monitor** blood sugars? □ Yes □ No	Which meter or CGM?	How often/time of day?	Usual readings?
Do you have a **family history** of diabetes? □ Mother □ Father □ Siblings □ Other		Time lost from work or school in the past year due to diabetes? □ Yes □ No How many days? _____	
Do you have any chronic **pain**? □ Yes □ No	If yes, where is it located?	Duration of pain?	Any treatment?
How would you rate the pain? 1 2 3 4 5 6 7 8 9 10 (10 is the worst and 1 is the least)			
Intentional **Exercise** or Activity? □ Yes □ No	Type:	Duration: _____ minutes/day, _____ days/week	
Highest level of **education** completed □ Grade School □ High School □ College	Problem with learning? □ Yes □ No	If Yes, Describe:	
Have you had any **diabetes education** before? □ Yes □ No	If yes, when and where?	Did friend/family participate? □ Yes □ No	
How do you learn best: : □ Listening □ Reading □ Observing □ Doing □ Other_____			
Do you have any difficulty with: □ Hearing □ Reading □ Seeing □ Speaking Please explain or list any other challenges that aren't listed _____			
Do you **smoke, vape or chew** tobacco? □ Yes □ No □ In the past	If yes, what type and how much?	Are you interested in tobacco cessation? □ Yes □ No	
Do you drink **alcohol**? □ Yes □ No	If yes, what type?	If yes, how much?	
How many people live in your home?	What are their relationships to you?		
Do you use community resources? (example: Health Department, Rappahannock Community Services Board) □ Yes □ No List: _____	Do you get a yearly flu shot? □ Yes □ No Have you ever had a pneumonia shot? □ Yes □ No Have you had the Hepatitis B shots? □ Yes □ No		
Within the past 12 months, I/we worried whether my food would run out before I/we got money to buy more. □ Yes □ No Within the past 12 months, the food I/we bought just didn't last and I/we didn't have money to get more. □ Yes □ No			
Do you have any special cultural needs? □ No □ If Yes, please list:			
Do you feel you have adequate support to manage your diabetes? □ Yes □ No			
On average, how many hours of sleep do you get? Weekdays _____ Weekends _____			
Check which apply to you: □ Trouble Falling Asleep □ Difficulty Staying Asleep □ Not Feeling Rested			
What are your feelings about your health and diabetes?			
Do you feel: Diabetes is serious? □ Yes □ No	Do you feel you can control your diabetes? □ Yes □ No		
I want to learn more about: □ Diet □ Exercise □ Stress Management □ Preventing Complications □ Glucose Testing □ Routine Monitoring for Risk Reduction/Target Values □ Other: _____			

FOR OFFICE USE ONLY: The above information has been reviewed and learning needs have been identified.
Education Needs/Plan: □ Disease Process □ Nutrition □ Physical Activity □ Using Medications □ Monitoring
□ Preventing Acute Complications □ Preventing Chronic Complications □ Behavior Change Strategies
□ Risk Reduction Strategies □ Psychosocial Adjustment □ Other: _____

_____ _____
Diabetes Educator Date