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

Please arrive 10 minutes prior to your initial appointment.

*We request a minimum of 24-hour notice if you must cancel or reschedule your appointment.

Please fill out the Health History form in this packet and bring it to your first appointment.

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.
- 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. Directions to our office are included in this packet.

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

Cathy Peterjohn, MS, RD, CDE
Program Manager

Our Educators:

Joanne Fortune, MS, RD, CDE
Stefanie Rekdal, RD, CDE, CPT
Laura Eubanks, RD, CDE, CPT
Parminder Singh, BSN, RN, CDE
Violet Jones, MS, RD, CDE
Jody Long, MS, RD
Maria Taeza-Pedroza, BSN, RN

Diabetes.mwhc.com
Rev. 07/2019
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.
INSTRUCTIONS
Please provide the information requested to help us serve you better. You may leave blank any areas of which you are uncertain, and the Diabetes Educator will review the information with you during your session.

**TO BE COMPLETED BY PATIENT.**

**DEMOGRAPHIC INFORMATION**

<table>
<thead>
<tr>
<th>Name</th>
<th>Email Address</th>
<th>Current Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>PREFERRED PHONE #</td>
<td>DATE OF BIRTH</td>
<td>NAME OF REFERRING PHYSICIAN</td>
</tr>
</tbody>
</table>

**GENERAL MEDICAL INFORMATION**

If you have any food allergies, please list them:

| Please list any chronic illness and date of diagnosis | Please list date/type of past surgeries. |

| Prescribed diabetes medications by MD | Over the counter supplements (i.e. vitamins, herbals, etc.) |

| High blood pressure | Yes | No |

**NUTRITION HISTORY: Please write what you eat and drink on a typical day.**

<table>
<thead>
<tr>
<th>Breakfast (time)</th>
<th>Lunch (time)</th>
<th>Dinner (time)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snack (A.M.)</td>
<td>Snack (P.M.)</td>
<td>Snack (bedtime)</td>
</tr>
</tbody>
</table>
# Diabetes History

**To Be Completed By Patient (pg. 2)**

<table>
<thead>
<tr>
<th>Type 1</th>
<th>Gestational</th>
<th>Length of time since diagnosis</th>
<th>If recently, signs and symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 2</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Treatment**

- Diet/Exercise
- Oral (pills)
- Insulin

<table>
<thead>
<tr>
<th>Name of insulin or oral drug</th>
<th>Dose</th>
<th>Side Effects</th>
</tr>
</thead>
</table>

**Monitor Blood Sugar?**

- Yes
- No

<table>
<thead>
<tr>
<th>Which meter?</th>
<th>How often/time of day?</th>
<th>Usual readings</th>
<th>Do you record results?</th>
</tr>
</thead>
</table>

- Yes
- No

Do you have family history of diabetes?

- Mother
- Father
- Sibling
- Other

- Yes
- No

Time lost from work or school in the past year due to diabetes?

- Yes
- No

**Pain Assessment**

- Do you have any chronic pain?
  - Yes
  - No

If yes, where located?

<table>
<thead>
<tr>
<th>Duration of pain?</th>
<th>Any treatment?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How would you rate the pain?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
</table>

(10 is the worst and 1 is the least)

Describe:

**Physical Activity Habits**

- Any restrictions for activity by MD:
  - Yes
  - No

Regular exercise program:

<table>
<thead>
<tr>
<th>Type and Duration:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Education History**

- Level of Education
  - Grade School
  - High School
  - College

- Problems 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

**Social History**

- Do you smoke?
  - Yes
  - No

- Do you drink alcohol?
  - Yes
  - No

- Do you have an eating disorder?
  - Yes
  - No

If yes, is your physician aware?

- Yes
- No

- Do you use community resources? (example -Health Department, Rappahannock Community Services Board)?
  - Yes
  - No

If yes, which ones?

How many people live in your home?

What are their relationships to you?

**Hygiene Patterns**

- Do you see a dentist once per year?
  - Yes
  - No

- Do you see an eye doctor once a year?
  - Yes
  - No

- Do you practice some form of contraception when not pregnant?
  - Yes
  - No

**Health Belief/Goals/Attitudes**

- Feelings about your health and diabetes?

- Areas of interest/concern for education session?

---

**To Be Completed by Diabetes Educator**

**HEIGHT**

<table>
<thead>
<tr>
<th></th>
<th>WEIGHT</th>
<th>PRE-PREGNANCY WT</th>
<th>EDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAST HISTORY OF GESTATIONAL DIABETES:</td>
<td>DELIVERY GOALS:</td>
<td>CHILD #1</td>
<td>CHILD #2</td>
</tr>
<tr>
<td>YES</td>
<td>NATURAL BIRTH</td>
<td>BIRTH WT</td>
<td>BIRTH WT</td>
</tr>
<tr>
<td>NO</td>
<td>MEDICATION</td>
<td>C-SECTION</td>
<td>C-SECTION</td>
</tr>
<tr>
<td>GRAVIDA/PARA</td>
<td>POST PARTUM GOALS:</td>
<td>VAGINAL</td>
<td>VAGINAL</td>
</tr>
<tr>
<td></td>
<td>BREASTFEED</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>BOTTLEFEED</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>COMBINATION</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**COMMENTS:**

<p>| | | | | | | |</p>
<table>
<thead>
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</thead>
</table>

Signature of Diabetes Educator

Date/Time

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Mary Washington Healthcare

Outpatient Diabetes Management Record

(Pregnant Patient)

FR-1184A-MWHO– Rev. 8/2018

PATIENT IDENTIFICATION

1 1/4" X 3"