



Mary Washington Hospital

Thank you for choosing Mary Washington Hospital Diabetes Self-Management Education and Support Services located in Cosner's Corner Office Park.

Your initial appointment is scheduled for:

Date: _____

Time from: _____ **to:** _____

Location: 4710 Spotsylvania Parkway, Suite 200, Fredericksburg, VA 22407

Please arrive 10 minutes prior to your scheduled time.

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

Please fill out the Health History enclosed 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 located on the reverse side of this letter.

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

Cathy Peterjohn, MS, RD, DCES
Program Manager

Our educators:

Stefanie Rekdal, RD, DCES, CPT
Laura Eubanks, RD, DCES, CPT
Jody Long, MS, RD

Parminder Singh, BSN, RN, DCES
Courtney Wilkerson, BSN, RN

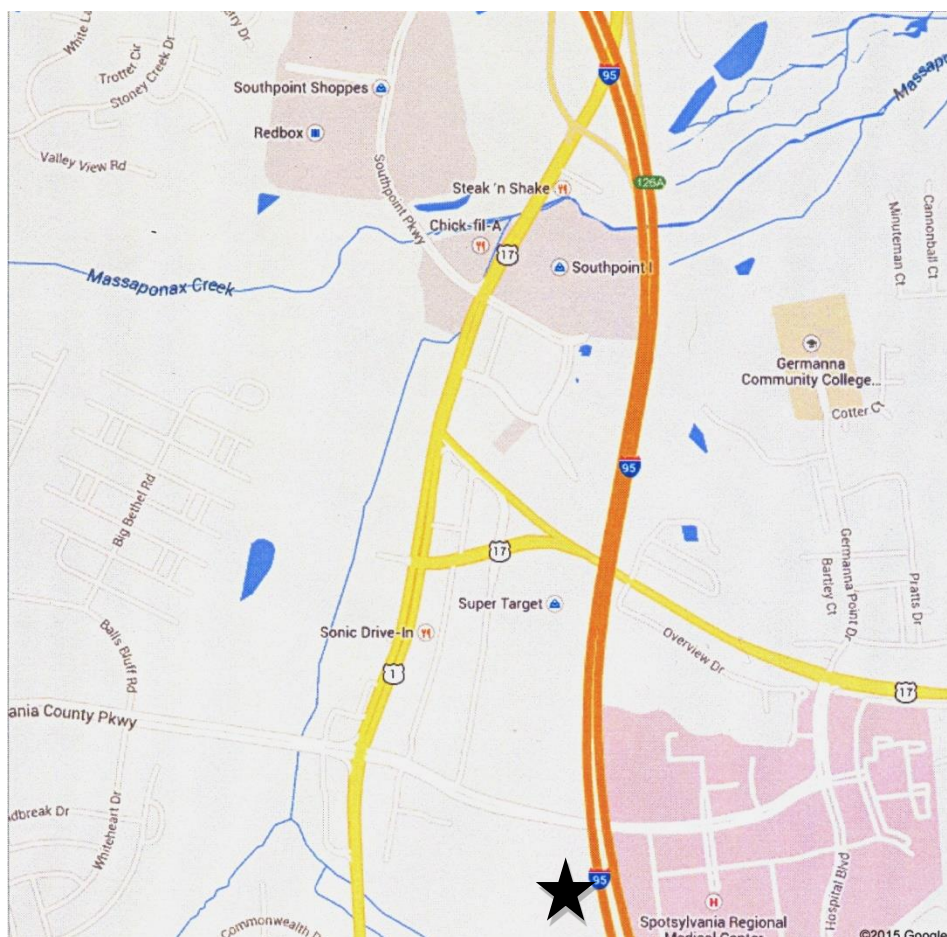
Directions to: Diabetes Management

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.



Demographic Information

Email address:

Sharing your email address allows us to communicate with you regarding your treatment plan and upcoming diabetes events.

Home Phone:	Cell Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Work Phone:	Occupation:	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
Name of Referring Physician:		Name of Family Physician:

General Medical Information

Are you allergic to any sulfa medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you have any known food allergies? <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list:
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Are you aware of the complications that may develop when you have diabetes? Yes No

Please mark if you have or have had any of the following:

Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol/Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye/Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last eye exam: _____
Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental/Mouth problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last dental exam: _____
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foot problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you check your feet daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Numbness or pain in hands, feet, or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty with sexual function	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Slowed stomach emptying	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment: _____
Have you ever been told you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do you use a CPAP/BiPAP machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If female, do you use contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type? _____

Please list any other illnesses not mentioned above: _____

Please list any significant surgical history: _____

Have you experienced episodes of:

<input type="checkbox"/> High blood sugar (250 or more)	occurs about _____ times a week/month/year
<input type="checkbox"/> Low blood sugar (70 or less)	occurs about _____ times a week/month/year
<input type="checkbox"/> Hospitalization due to diabetes	occurs about _____ times a year

Diabetes History

Type: <input type="checkbox"/> Type 1 <input type="checkbox"/> Gestational <input type="checkbox"/> Type 2 <input type="checkbox"/> Unsure	Date of Diabetes Diagnosis:	How did you learn you have diabetes?
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RN3890



Outpatient Diabetes Health History Record

FR-1184-MWHC Rev. 6/2020

PATIENT IDENTIFICATION
1 1/4" X 3"

Treatment: <input type="checkbox"/> Diet/Exercise <input type="checkbox"/> Oral (pills) <input type="checkbox"/> Injectable Meds		Name and Dose of Diabetes Medication(s)		Side Effects
Do you monitor blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No		Which meter or CGM?	How often/time of day?	Usual readings?
Do you have a family history of diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Other			Time lost from work or school in the past year due to diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days? _____	
Pain Assessment				
Do you have any chronic pain? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, where 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)				
Physical Activity Habits				
Intentional Exercise or Activity? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Duration: _____ minutes/day, _____ days/week	
Education History				
Highest level of education completed <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College		Problem with learning? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe:	
Have you had any diabetes education before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when and where?	Did friend/family participate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social History				
Do you smoke, vape or chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what type and how much?	Are you interested in smoking cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____			Do you get a yearly flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a pneumonia shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had the Hepatitis B shots? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within the past 12 months, I/we worried whether my food would run out before I/we got money to buy more. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any special cultural needs? <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list:				
Do you feel you have adequate support to manage your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No				
On average, how many hours of sleep do you get? Weekdays _____ Weekends _____				
Check which apply to you: <input type="checkbox"/> Trouble Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Not Feeling Rested				
Health Belief/Goals/Attitudes				
Feelings about your health and diabetes?				
Do you feel: Diabetes is serious? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you feel: You can control your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I want to learn more about: <input type="checkbox"/> Diet <input type="checkbox"/> Exercise <input type="checkbox"/> Preventing complications <input type="checkbox"/> Stress Management <input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Tests to take regularly and target values <input type="checkbox"/> Other: _____				
For office use only: The above information has been reviewed and learning needs have been identified.				
Diabetes Educator _____			Date _____	
 Mary Washington Healthcare			PATIENT IDENTIFICATION 1 1/4" X 3"	
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