Stafford Hospital

MWHC

Thank you for choosing Stafford Hospital Diabetes Self-Management Education and Support Services located at the Stafford Medical Pavilion, 125 Hospital Center Blvd. Ste. 217, Stafford, VA 22554

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 form in this packet and bring it to your first appointment.

As a courtesy, Stafford 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 for 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. Stafford 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.

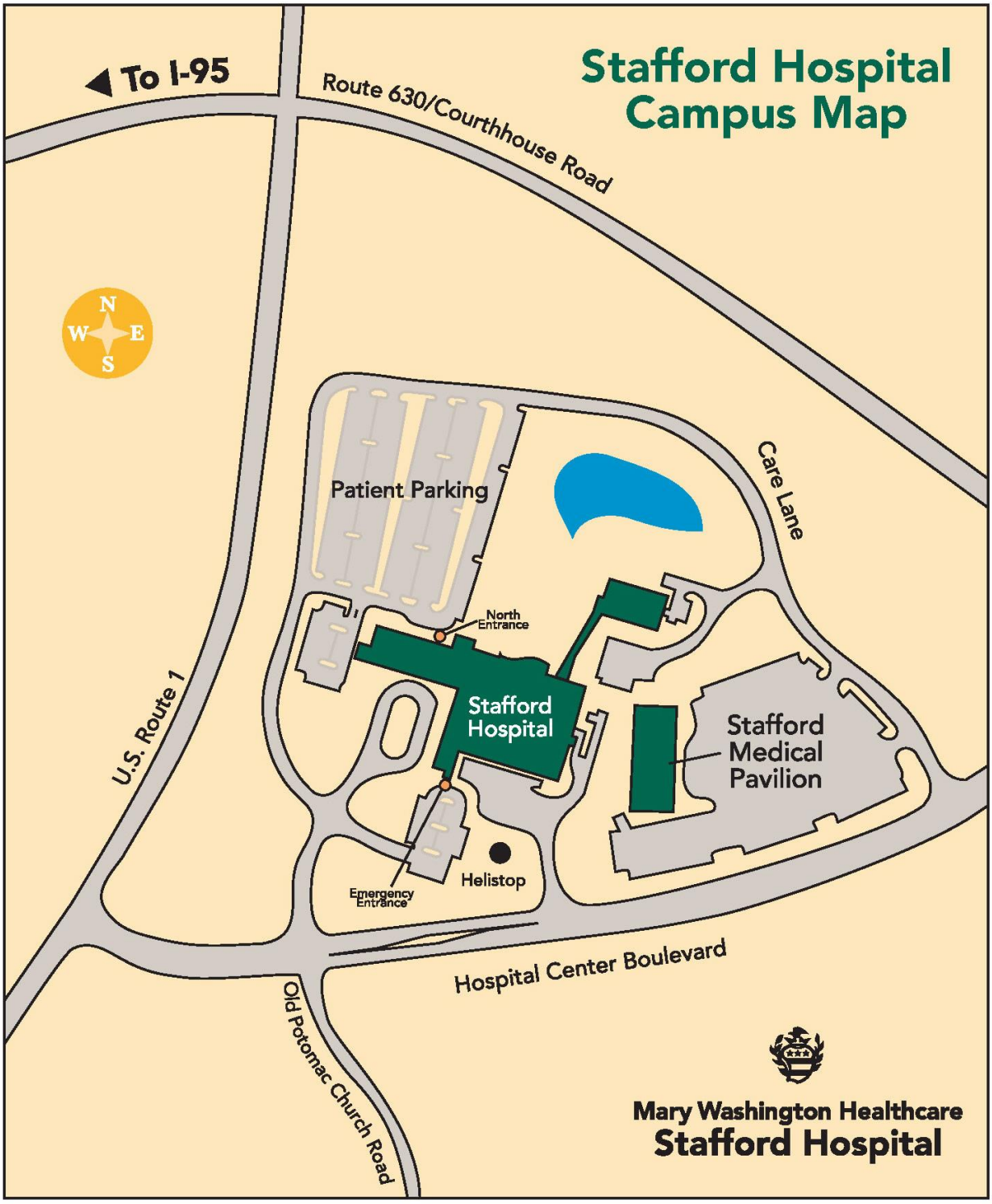
If you have any questions, please feel free to contact us at 540.741.2210.

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

Rev. 07/2019



To Stafford Hospital campus

From the south—I-95 North to exit 140. Turn right onto Courthouse Road/Route 630 (approx. 1 mile).
From the north—I-95 South to exit 140. Turn left onto Courthouse Road/Route 630 (approx. 1 mile).

From Courthouse Rd., turn right on Route 1 (approx. ½ mile). Turn left onto Hospital Center Boulevard. The third left will take you to the parking lot for the Medical Pavilion. Once inside the Pavilion, look for Suite 217, located on second floor. It will say Diabetes Management Program on the door. Nutrition Counseling is in the same suite.

Demographic Information

Email address (By including your email address you are allowing us to communicate with you regarding your treatment plan, upcoming diabetes events and updates)

Home Phone	Cell Phone	Sex □ Male □ Female
Work Phone	Occupation	Marital Status □ S □ M □ W □ D

Name of Referring Physician:	Name of Family Physician

General Medical Information

Are you allergic to any **sulfa** medications? □ Yes □ No □ Unknown	Do you have any known **food** allergies? □ Yes □ No If yes, please list:
List any past illnesses and dates of the illness	Past surgeries and dates of surgery:

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	□ 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	
Circulation problems	□ Yes	□ No	
Numbness or pain in hands, feet, or legs	□ Yes	□ No	
Difficulty with sexual function	□ Yes	□ No	
Slowed stomach emptying	□ Yes	□ No	
Stroke	□ Yes	□ No	
Depression	□ Yes	□ No	Treatment: _____
Any other medical conditions?	□ Yes	□ No	List: _____
			_____
Have you ever been told you have sleep apnea?	□ Yes	□ No	
If yes, do you use a CPAP machine?	□ Yes	□ No	
If female do you use contraception?	□ Yes	□ No	If yes, what type? _____

Have you experienced episodes of:

□ Diabetic ketoacidosis	□ Yes □ No
□ High blood sugar (250 or more)	occurs about _____ times a week/month/year
□ Low blood sugar (70 or less)	occurs about _____ times a week/month/year
□ Ketones in urine	occurs about _____ times a week/month/year
□ Hospitalization due to diabetes	occurs about _____ times a year.

Mary Washington Healthcare

RN3890

Outpatient Diabetes Health History Record

FR-1184-MWHC Rev. 8/2018

PATIENT IDENTIFICATION
1 1/4" X 3"

Diabetes History

Type:	Date of Diabetes Diagnosis:	How did you learn you have diabetes?
□ Type 1 □ Gestational □ Type 2 □ Other		

Treatment:	Name of insulin or oral drug	Dose	Side Effects
□ Diet/Exercise □ Byetta □ Oral (pills) □ Symlin □ Insulin □ _____			

Do you monitor blood sugars?	Which meter?	How often/time of day?	Usual readings?	Do you record results?
□ Yes □ No				□ Yes □ No

Do you have a family history of diabetes?	Time lost from work or school in the past year due to diabetes?
□ Mother □ Father □ Siblings □ Other	□ Yes □ No How many days? _____

Pain Assessment

Do you have any chronic pain?	If yes, where located?	Duration of pain?	Any treatment?
□ Yes □ No			

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)
Describe:

Physical Activity Habits

Regular Exercise Program?	Type:	Duration:
□ Yes □ No		

Education History

Highest level of education completed	Problem with learning?	If Yes, Describe:
□ Grade School □ High School □ College	□ Yes □ No	
Have you had any diabetes education before?	If yes, when and where?	Did friend/family participate?
□ Yes □ No		□ Yes □ No

Social History

Do you smoke? □ Yes □ No	If yes, what type and how much?	Are you interested in smoking 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 received the Hepatitis B Vaccination? □ Yes □ No (CDC guidelines for Hep B vaccine include adults 19-59; ≥ 60yrs/clinician)

Do you have any special cultural needs?

Health Belief/Goals/Attitudes

Feelings about your health and diabetes?

Rate your health: □ excellent □ good □ fair □ poor

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 □ Preventing complications of diabetes □ Stress Management
□ How to test my blood sugar □ Tests to take regularly and target values □ Other: _____

For Office Use Only: Height: _____ Weight: _____ Usual Weight: _____
The above information has been reviewed and learning needs have been identified.
Comments:

_____ _____
Diabetes Educator Date/Time

Mary Washington Healthcare

Outpatient Diabetes Health History Record

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PATIENT IDENTIFICATION
1 1/4" X 3"