Demographic Information

Email address		
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 medications, please list them:	Other allergies, please list them:
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.

_____ _____

Diabetes Educator Date

RN3890

Mary Washington Healthcare

Outpatient Diabetes Health History Record

FR-1184-MWHC Rev. 1/2010

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

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:

_____ _____
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