



# Mary Washington Hospital

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 (included in 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.

Paquita Gillard  
Operations Manager

## Our educators:

Stefanie Rekdal, BS, RD, CDCES, CPT  
Shanta Jackson, BS, RD  
Parminder Singh, BSN, RN, CDCES, CPT  
Courtney Wilkerson, BSN, RN, CDCES, CPT  
Sarah Whitson, BS, RD, CDCES  
Elsa Nicholson, BS, RD

### 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**

NAME	DATE OF BIRTH	OCCUPATION	CURRENT DATE
PREFERRED PHONE #	EMAIL ADDRESS	NAME OF REFERRING PHYSICIAN	

#### **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 <input type="checkbox"/> YES <input type="checkbox"/> NO	

#### ***NUTRITION HISTORY: PLEASE WRITE WHAT YOU EAT AND DRINK ON A TYPICAL DAY.***

BREAKFAST (TIME)	LUNCH (TIME)	DINNER (TIME)
SNACK (A.M.)	SNACK (P.M.)	SNACK (BEDTIME)

**Yes/No** Within the past 12 months we/I worried whether our food would run out before we got money to buy more.

**Yes/No** Within the past 12 months the food we/I bought just didn't last and we/I didn't have money to get more.

\*RN4705\*



**Outpatient Diabetes Management Record  
(Pregnant Patient)**

FR-1184A-MWHC- Rev. 6/2020

PATIENT IDENTIFICATION  
1 1/4" X 3"

Diabetes History <span style="float: right;">To Be Completed By Patient (pg. 2)</span>				
Type 1 Type 2	Gestational Other	Length of time since diagnosis		If recently, signs and symptoms
Treatment Diet/Exercise Oral (pills): Please list name(s) and doses _____ Insulin: Please list type(s) and doses _____				
Monitor Blood Sugar? Yes No	Which meter?	How often/time of day?	Usual readings	Do you record results? Yes No
Do you have family history of diabetes? Mother Father Sibling Other:		Time lost from work or school in the past year due to diabetes? Yes No How many days?		
Pain Assessment				
Do you have any chronic pain? Yes 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) Describe:				
Physical Activity Habits				
Any restrictions for activity by MD: Yes No		Regular exercise program: Yes No	Type and Duration:	
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? No Yes, when and where?			Did friend/family participate? Yes No	
Social History				
Do you smoke, vape or chew tobacco? 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? ( <i>example</i> -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	WEIGHT	PRE-PREGNANCY WT	EDC	<input type="radio"/> SINGLE BIRTH <input type="radio"/> MULTIPLE BIRTH
PAST HISTORY OF GESTATIONAL DIABETES: <input type="radio"/> YES <input type="radio"/> NO GRAVIDA/PARA _____/____	DELIVERY GOALS: <input type="radio"/> NATURAL BIRTH <input type="radio"/> MEDICATION POST PARTUM GOALS: <input type="radio"/> BREASTFEED <input type="radio"/> BOTTLEFEED <input type="radio"/> COMBINATION	CHILD #1 BIRTH WT <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL	CHILD #2 BIRTH WT <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL	CHILD #3 BIRTH WT _____ <input type="radio"/> C-SECTION <input type="radio"/> VAGINAL
COMMENTS:				
Signature of Diabetes Educator _____			Date/Time _____	

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