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. 125, Stafford, VA 22554.

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, Stafford Hospital will bill your insurance company for your diabetes education.

We request that you:

- Bring your completed Health History form and distress assessment (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 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.

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

Scan with your phone's camera for directions.

Name:	Cell Phone:	Sex: □ Male □ Female
Occupation:	Marital Status: □ S □ M □ W □ D	Gender:
Name of Referring Physician:	Name of Family Physician:	
Are you allergic to any **sulfa** medications? □ Yes □ No □ Unknown	Do you have any diagnosed **food** allergies? □ No □ If Yes, please list:	

Are you aware of the **complications** that may develop when you have diabetes? □ Yes □ No
What **type** of Diabetes do you have? □ Type 1 □ Type 2 □ Gestational □ Unsure
When and how were you **diagnosed** with Diabetes? _____

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	Date of last **foot exam** (by physician):_____
Circulation problems	□ Yes	□ No	
Numbness or pain in hands, feet, or legs	□ Yes	□ No	
Difficulty with sexual function	□ Yes	□ No	
Gastroparesis	□ Yes	□ No	
Stroke	□ Yes	□ No	
Depression	□ Yes	□ No	Treatment: _____
Have you ever been told you have sleep apnea?	□ Yes	□ No	
If yes, do you use a CPAP/BiPAP machine?	□ Yes	□ No	
If female, do you use contraception?	□ Yes	□ No	

Please list any **other illnesses** not mentioned above: _____

_____

Please list any significant **surgical history**: _____

_____

HAVE YOU EXPERIENCED:

Low blood sugar (70 or below)?	□ Yes	□ No
Hospitalization for your diabetes?	□ Yes	□ No

Name and Dose of **Diabetes** Medication(s): □ N/A	Side Effects

Do you **monitor** blood sugars? □ Yes □ No	Which meter or CGM?	How often/time of day?	Usual readings?

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

Do you have any chronic **pain**? □ Yes □ No	If yes, where is it 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)

Intentional **Exercise** or Activity? □ Yes □ No	Type/Frequency (Ex: walking 30 minutes 3 days/week)

Highest level of **education** completed □ Grade School □ High School □ College	Problem 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

How do you learn best: : □ Listening □ Reading □ Observing □ Doing □ Other_____

Do you have any difficulty with: □ Hearing □ Reading □ Seeing □ Speaking Please explain or list any other challenges that aren't listed _____

Do you **smoke, vape or chew** tobacco? □ Yes □ No □ In the past	If yes, what type and how much?	Are you interested in tobacco cessation? □ Yes □ No
Do you drink **alcohol**? □ Yes □ No	If yes, what type and how much per week?	
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 had the Hepatitis B shots? □ Yes □ No

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

Do you have any special cultural needs? □ No □ If Yes, please list:

Do you feel you have adequate support to manage your diabetes? □ Yes □ No

On average, how many hours of sleep do you get? Weekdays _____ Weekends _____

Check which applies to you: □ Trouble Falling Asleep □ Difficulty Staying Asleep □ Not Feeling Rested

Why is managing your diabetes important to you?

What are your biggest challenges in managing your diabetes?

I want to learn more about: □ Diet □ Exercise □ Stress Management □ Preventing Complications □ Glucose Testing
□ Routine Monitoring for Risk Reduction/Target Values □ Other: _____

FOR OFFICE USE ONLY: The above information has been reviewed and learning needs have been identified.
Education Needs/Plan: □ Disease Process □ Nutrition □ Physical Activity □ Using Medications □ Monitoring
□ Preventing Acute Complications □ Preventing Chronic Complications □ Behavior Change Strategies
□ Risk Reduction Strategies □ Psychosocial Adjustment □ Other: _____

_____ _____
Diabetes Educator Date

NAME: _____

Type 2 Diabetes Distress Assessment System

Identifying the Sources of Distress

Living with diabetes can be tough. Listed below are many of the stresses and worries that people with diabetes often experience. Thinking back over the past month, please indicate how much each of the following items were a problem for you by marking the appropriate column.

	NOT A PROBLEM	A SMALL PROBLEM	A MODERATE PROBLEM	A SERIOUS PROBLEM	A VERY SERIOUS PROBLEM
1. It bothers me that I don't get as much exercise as I should.					
2. It frustrates me that my eating often feels out of control.					
3. I often feel ashamed or embarrassed when other people know about my diabetes.					
4. I worry a lot about developing serious complications from diabetes.					
5. I worry a lot that I could have a serious low glucose event.					
6. I worry that I won't be able to pay for my diabetes care, medications, or supplies.					
7. I worry that I can't get the healthy food I need for my diabetes.					
8. I worry about how hard it is to get to my healthcare appointments or pharmacy.					
9. It frustrates me that people in my life tempt me to eat food or do things that are not good for my diabetes.					
10. It hurts me that many people in my life don't understand what living with diabetes is really like.					