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 (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.

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 ☐ YES ☐ 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.

PATIENT IDENTIFICATION
1 1/4" X 3"

Diabetes History	**To Be Completed By Patient (pg. 2)**	
Type 1 Gestational Type 2 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? (*example* -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	○ SINGLE BIRTH ○ MULTIPLE BIRTH
PAST HISTORY OF GESTATIONAL DIABETES: ○ YES ○ NO GRAVIDA/PARA _____/_____	DELIVERY GOALS: ○ NATURAL BIRTH ○ MEDICATION POST PARTUM GOALS: ○ BREASTFEED ○ BOTTLEFEED ○ COMBINATION	CHILD #1 BIRTH WT _____ ○ C-SECTION ○ VAGINAL	CHILD #2 BIRTH WT _____ ○ C-SECTION ○ VAGINAL	CHILD #3 BIRTH WT _____ ○ C-SECTION ○ VAGINAL
		COMMENTS:		

_____ **Signature of Diabetes Educator**

_____ **Date/Time**

RN4705

Mary Washington Healthcare

PATIENT IDENTIFICATION
1 1/4" X 3"

Outpatient Diabetes Management Record
(Pregnant Patient)
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