# 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.

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

Daniell McKiver
Operations Manager

Our Educators:

Stefanie Rekdal, RD, DCES, CPT
Laura Eubanks, RD, DCES, CPT
Jody Long, MS, RD, DCES
Parminder Singh, BSN, RN, DCES
Courtney Wilkerson, BSN, RN

Rev. 10/2020

**Demographic Information**

Email address:
Sharing your email address allows us to communicate with you regarding your treatment plan and upcoming diabetes events.

| | | |
|---|---|---|
| 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?<br>□ Yes □ No □ Unknown | Do you have any known **food** allergies?<br>□ No □ If Yes, please list: |

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: _____ |
| 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 | If yes, what type? _____ |

Please list any other illnesses not mentioned above: _____

_____

Please list any significant surgical history:_____

**Have you experienced episodes of:**

□ 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
□ Hospitalization due to diabetes occurs about _____ times a year

**Diabetes History**

| | | |
|---|---|---|
| Type: □ Type 1 □ Gestational<br>□ Type 2 □ Unsure | Date of Diabetes Diagnosis: | How did you learn you have diabetes? |

*RN3890*

Mary Washington Healthcare

**Outpatient Diabetes Health History Record**

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PATIENT IDENTIFICATION
1 1/4" X 3"

| Treatment:<br>□ Diet/Exercise □ Oral (pills)<br>□ Injectable Meds | Name and Dose of **Diabetes** Medication(s) | | Side Effects |
|---|---|---|---|
| Do you monitor blood sugars?<br>□ Yes □ No | Which meter or CGM? | How often/time of day? | Usual readings? |
| Do you have a family history of diabetes?<br>□ Mother □ Father □ Siblings □ 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?<br>□ 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) | | | |
| **Physical Activity Habits** | | | |
| Intentional Exercise or Activity?<br>□ Yes □ No | Type: | Duration:<br>_____ minutes/day, _____ days/week | |
| **Education History** | | | |
| Highest level of education completed<br>□ Grade School □ High School □ College | Problem with learning?<br>□ Yes □ No | If Yes, Describe: | |
| Have you had any diabetes education before?<br>□ Yes □ No | If yes, when and where? | Did friend/family participate?<br>□ Yes □ No | |
| **Social History** | | | |
| Do you smoke, vape or chew tobacco?<br>□ 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)<br>□ Yes □ No List: _____ | Do you get a yearly flu shot? □ Yes □ No<br>Have you ever had a pneumonia shot? □ Yes □ No<br>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<br>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 apply to you: □ Trouble Falling Asleep □ Difficulty Staying Asleep □ Not Feeling Rested | | | |
| **Health Belief/Goals/Attitudes** | | | |
| Feelings about your health and diabetes? | | | |
| 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 □ Stress Management<br>□ Blood sugar testing □ Tests to take regularly and target values □ Other: _____ | | | |

**For office use only:** The above information has been reviewed and learning needs have been identified.

_____ _____

Diabetes Educator Date

*RN3890*

Mary Washington Healthcare

**Outpatient Diabetes Health History Record**

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