



Stafford Hospital

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 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 (on pages 2–3 of 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.

Daniell McKiver
Operations Manager

Our educators:
Stefanie Rekdal, RD, CDCES, CPT
Jody Long, MS, RD, CDCES
Parminder Singh, BSN, RN, CDCES
Courtney Wilkerson, BSN, RN, CDCES
Sarah Whitson, BS, RD



Scan me with your phone camera for Google maps directions.

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?

Yes No Unknown

Do you have any known **food** allergies?

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
 Type 2 Unsure

Date of Diabetes Diagnosis:

How did you learn you have diabetes?

RN3890



Outpatient Diabetes Health History Record

FR-1184-MWHC Rev. 6/2020

PATIENT IDENTIFICATION
1 1/4" X 3"

Treatment: <input type="checkbox"/> Diet/Exercise <input type="checkbox"/> Oral (pills) <input type="checkbox"/> Injectable Meds		Name and Dose of Diabetes Medication(s)		Side Effects
Do you monitor blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No		Which meter or CGM?	How often/time of day?	Usual readings?
Do you have a family history of diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Other			Time lost from work or school in the past year due to diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days? _____	
Pain Assessment				
Do you have any chronic pain? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Duration: _____ minutes/day, _____ days/week	
Education History				
Highest level of education completed <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College		Problem with learning? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe:	
Have you had any diabetes education before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when and where?	Did friend/family participate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Social History				
Do you smoke, vape or chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what type and how much?	Are you interested in smoking cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> 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) <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____			Do you get a yearly flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a pneumonia shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had the Hepatitis B shots? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Within the past 12 months, I/we worried whether my food would run out before I/we got money to buy more. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any special cultural needs? <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list:				
Do you feel you have adequate support to manage your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No				
On average, how many hours of sleep do you get? Weekdays _____ Weekends _____				
Check which apply to you: <input type="checkbox"/> Trouble Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Not Feeling Rested				
Health Belief/Goals/Attitudes				
Feelings about your health and diabetes?				
Do you feel: Diabetes is serious? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you feel: You can control your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I want to learn more about: <input type="checkbox"/> Diet <input type="checkbox"/> Exercise <input type="checkbox"/> Preventing complications <input type="checkbox"/> Stress Management <input type="checkbox"/> Blood sugar testing <input type="checkbox"/> Tests to take regularly and target values <input type="checkbox"/> Other: _____				
For office use only: The above information has been reviewed and learning needs have been identified.				
Diabetes Educator _____			Date _____	
 Mary Washington Healthcare			PATIENT IDENTIFICATION 1 1/4" X 3"	
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