Baptist Health Lexington
Outpatient Diabetes Services
Diabetes Assessment Form

BAPTIST HEALTH LEXINGTON

Diabetes Education & Nutrition Education

Please answer as many questions as you can. Someone can help you fill this out if needed.

General Information

1. Name: (Mr /Ms/ Mrs) _____
2. Birthdate: _____
3. Where do you work? _____
4. What do you do? _____
5. Last grade of school completed: _____

Medical Information

1. Height _____ Weight _____ Have you had weight changes? Yes or No
   If yes, please describe: _____
   What is your desirable body weight? _____
2. Have you in the past or do you currently use tobacco products? Currently In past Never
   If yes, what and how much each day?_____ For how long? _____years
   Have you been advised to quit? _____ By Whom? _____When?_____
   Would you like info on quitting? Yes or No If you have quit, when? _____
3. Do you consume alcohol? Yes or No
   If yes, what and how much and how often? _____

4. Please fill in as much information you can on the most recent lab work:

Blood pressure _____	Date _____	Glucose _____	Date _____
Triglyceride _____	Date _____	Urine Microalbumin _____	Date _____
Last HgA1c _____	Date _____	Cholesterol _____	Date _____
HDL _____	Date_____	LDL _____	Date_____

Dates of last eye exam_____ last foot exam _____last physical exam _____

5. Do you have any allergies (including food allergies or intolerances) Yes or No
   If yes, please describe: _____

6. What medical problems are you being treated for currently? (*please list)*

7. How would you rate your current health? *(circle one)*

EXCELLENT GOOD FAIR POOR

8. Please list your current daily medications below:

Drug Name	**How much and how often do you take it?**	**When did you start taking this drug?**	**Which doctor ordered this drug for you?**

9. How often do you skip your diabetes medication(s)? _____

Diabetes History

1. What type of diabetes do you have? *(circle one)*

Type 1 **Type 2** **Gestational** **Pre-Diabetes** **"I don't know"**

2. How long have you had diabetes? _____ years **OR** Newly diagnosed

3. Does anyone in your family have diabetes? Yes or No If yes, who?_____

4. Have you had diabetes education/teaching in the past? Yes or No

If yes, when and where?_____

5. Do you test your blood sugar at home? Yes or No If yes, answer the following questions:

What meter do you use? _____ Who performs the test? _____

How often do you test? _____ What are your numbers? _____

6. Have you had low blood sugar (less than 70 mg/dl)? _____

If yes, how often do you have low blood sugar? *(circle one)*

Unknown Rare Occasionally Frequently

When was your last low blood sugar? _____

How do you treat low blood sugar? _____

7. Have you had high blood sugar (more than 140 mg/dl)? _____

If yes, how often do you have high blood sugar? *(circle one)*

Unknown Rare Occasionally Frequently

When was your last high blood sugar? _____

How do you treat high blood sugar? _____

8. How would you rate your diabetes control? *(circle one)*

EXCELLENT GOOD FAIR POOR

9. How would you rate your understanding of diabetes care? *(circle one)*

EXCELLENT GOOD FAIR POOR

10. How often do you check your feet? (*circle one*) DAILY WEEKLY NEVER

11. Do you perform your own nail care? Yes or No

12. How do you feel about having diabetes? _____

13. Has diabetes caused a problem in your life (work/school/family/friends, etc.)? Yes or No

If yes, describe: _____

14. What makes it difficult for you to take care of your diabetes or yourself? Please describe:

_____

15. Do you have any diabetes complications? *(circle all that apply)*

Circulation problems	Foot ulcers	Heart disease
Impotency	Recurring infections	Retinopathy
Neuropathy	Nephropathy	Blindness
Glaucoma	Amputations	Laser Surgery

16. Do you have high blood pressure (hypertension)? Yes or No

If yes, are you currently being treated for it? Yes or No

17. What areas of diabetes would you like to learn about? (*circle as many as desired)*

Understanding diabetes	Medications for diabetes
Avoiding high blood sugar	Avoiding low blood sugar
Diet information	Exercise information
Stress/coping skills	Diabetes complications
Testing my blood sugar at home	Resources on diabetes
Planning for pregnancy with diabetes	Insulin pumps
Pregnancy and diabetes	OTHER: _____

18. To help the teacher provide a good experience for you, please share any of the information about yourself so we can support your needs in class: *(circle all that apply)*

Hearing loss	Vision loss (cannot read newspaper)
Reading problems	Manual dexterity problems
Changes in sensation	Financial stress/problems
Religious influences about health	Other: _____

19. How do you learn information best? *(circle one)*

Discussion Listening Reading Watching (visual) Doing

20. Do you use computers to email? Yes or No

Do you use computers or phone app's for health information/record keeping? Yes or No

Nutrition Information:

1. When was the last time you saw a dietitian? _____
   Are you currently following a special meal plan? *(circle one*) Never Occasionally Frequently

2. How often do you eat the following foods:

Milk	_____ times each day	Ice Cream	_____times each day
Fruit	_____ times each day	Snack Foods	_____ times each day
Vegetables	_____ times each day	Pop	_____ # day (diet or regular?)
Juice	_____ times each day	Ethnic foods	_____ times each day
Candy/Chocolate	_____ times each day	Alcohol	_____ times each day
Baked goods	_____ times each day	Caffeine	_____ times each day
Desserts	_____ times each day	Artificial Sweeteners:	_____ servings/day

3. Please write down everything you can remember you ate in the last 24 hours (1 day).
Write down when, what, and how much you ate in the space below. Don't forget drinks.

What Time	What You Ate	How Much
Breakfast	*Example: Cheerio, skim milk*	*Example: 1 cup cereal, 1/2 cup milk*
Snack		
Lunch		
Snack		
Dinner		
Snack		

4. How many meals do you eat each day? _____ How many snacks? _____

5. How often do you eat out? _____ times a week. If you eat out, where?

6. Do you use Food Assistance programs (WIC, food stamps, food bank) Yes or No
7. Do you need information about Food Assistance programs? Yes or No

8. What challenges do you have with your diet?

_____

9. Please describe how the following issues affect your eating habits.

Issue	**How does the issue affect you**
Food finances	
Activity	
Eating in response to stress	
Eating out	
Eating disorder	
Occupation/shiftwork	
Grocery shopping	
Meal preparation	
Other food restrictions	
Social/prescription drugs	
Vitamin/Mineral supplements	
Herbal supplements	
Alcohol	
Caffeine	

10. Are you currently involved in physical activity/exercise regimen? Yes or No
If yes, what exercise _____ How much _____

11. **Support Plan:** What type of support do you currently use to help you with your health issues? (*Example: gym membership, Weight Watchers classes, friend who walks with you, books)*

Please write any other information you would like to share below:

For PREGNANT patients ONLY, please answer the following:

When is your due date _____

What was your usual pre-pregnancy weight? _____

Do you plan to breast feed or bottle feed? _____

How much weight have you gained in the last month? _____

Are you taking prenatal vitamins? _____

Do you have indigestion or other food related problem? **Yes or No**

If yes, please describe: _____

Please sign your name and write today's date:

Signature: _____ ***Date:*** _____

Instructor: _____

Instructor: _____

Diabetes Education & Nutrition Education

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BAPTIST HEALTH
LEXINGTON

Dear Participant,

We are asking our patients to help us learn how well patients can understand the medical information that the nurses and dietitians give them. Your answers will help us learn how to provide medical information in ways that patients will understand. This questionnaire has 6 questions and it will only take about 3 minutes to complete. Answer the questions as best as you can. It is okay to leave an answer blank. After completion, please bring the answer sheet along with your completed assessment form to your appointment. Thank you for your time.

Baptist Health Lexington
Outpatient Diabetes and Nutrition Services
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Diabetes Education
&
Nutrition Education

This information is on the back of a container of a pint of ice cream (see below for label).

1. If you eat the entire container, how many calories will you eat?
   Answer: _____

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
   Answer: _____

3. Your doctor advices you to reduce the amount of saturated fat in your diet. You usually have 42g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
   Answer: _____

4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
   Answer:_____

5. Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves, and bee stings.
   Is it safe for you to eat this ice cream? Yes or No (please circle the correct answer)
   If no, why not? Answer:_____

Ice Cream Label

Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Please check one:

◊ I completed the questionnaire on my own
◊ I had help answering these questions
◊ I do not wish to fill this out

Thank you for your participation.

Place patient sticker here
(for office use only)