The Everett Clinic

Part of Optum®

3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

Patient label here or

Patient name: _____

Date of birth: _____

MRN: _____

Diabetes self-management program history form

Please print your responses on this form.

Please tell us about yourself

Name:_____ Ethnicity: (optional) _____

What kind of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Gestational diabetes ☐ Don't know

How long have you had diabetes? _____

Do you check your blood sugar level at home? ☐ no ☐ yes If yes, what is the typical range? _____

What is your blood sugar target or goal? _____

How often do you check your blood sugar level? ☐ sometimes ☐ once per day ☐ two or more times per day

When do you test? (check all that apply) ☐ before breakfast ☐ before other meals
☐ after meals (how long after) _____ ☐ bedtime ☐ other _____

In the last month, how often did you have a low blood sugar level? _____

At what number do you feel a low blood sugar level? _____ How you take care of your low blood sugar? _____

Do you know the results of your last Hemoglobin A1c test? ☐ no ☐ yes Result: _____

How do you feel about having diabetes? _____

Rate your recent level of stress: 1 means low, 5 means high ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What do you want to learn about diabetes? _____

Have you attended previous diabetes education sessions? ☐ no ☐ yes How long ago? _____

Do you have concerns with any of the following that may make learning difficult?
☐ vision ☐ hearing ☐ language ☐ your reading skills ☐ other: _____

What is the last grade of school you completed? _____

Check all of the terms that describe the support you get from other people for your diabetes:
☐ family ☐ friends ☐ co-workers ☐ health care providers ☐ support group ☐ none other: _____

Medical history

Please check all medical conditions or problems that you have now or have had in the past.

☐ Heart disease
☐ High blood pressure
☐ Kidney (organs that filter blood) problems
☐ High cholesterol, lipids
☐ Gestational diabetes
☐ Foot problems, nerve pain
☐ Eye problems
☐ Impotence
☐ Thyroid condition
☐ Sleep apnea
☐ Depression
☐ Current smoker
☐ Other: _____

Are you pregnant? ☐ no ☐ yes Do you plan to become pregnant in the future? ☐ no ☐ yes

List all the medications you take for diabetes (and the amounts if you know):

_____

Exercise and weight

Do you exercise (physical movement) regularly? ☐ no ☐ yes If yes, what kind of exercise do you do? _____

Times per week: _____ Minutes: _____ List anything that stops you from getting exercise: _____

Height: _____ Weight: _____ What is your goal weight or ideal weight? _____

Has your weight changed in the past three months ☐ no ☐ yes Were you trying to lose weight? ☐ no ☐ yes

How many pounds did you lose _____ or gain _____?

Schedule

What time do you get up? _____ What time do you go to bed? _____

Job: _____Work hours: _____ Is your work physical? ☐ no ☐ yes If yes, please describe: _____

Diet (your eating plan)

Do you drink alcohol? ☐ no ☐ yes If yes, what kind of alcohol do you drink? _____
How much alcohol do you drink? _____ How often do you drink? _____
Do you drink milk? ☐ no ☐ non-fat ☐ 1% ☐ 2% ☐ whole ☐ other _____ How much daily? _____
Do you drink regular soda or fruit juice? ☐ no ☐ yes If yes, what kind? _____How much? _____
How many servings of fruit do you eat daily? _____How many servings of vegetables do you eat daily? _____
Are you following any special diet now? ☐ no ☐ yes If yes, please describe: _____
Describe any cultural or religious practices that influence your diet: _____
List any food allergies or intolerances (food that you have a bad physical response to):

_____
List any of your challenges to eating healthy: _____
Who does the food shopping and cooking at home? _____
Meals out per week: _____ Types of restaurants: _____
Do you take any supplements or herbs? _____

Please list what you eat in a typical day:

Breakfast	Snack	Lunch	Snack	Dinner	Snack
Time:	**Time:**	**Time:**	**Time:**	**Time:**	**Time:**

How do you feel about your health habits?

☐ Not ready to change ☐ Thinking about changes
☐ Planning changes ☐ Starting changes ☐ Maintaining good health habits

_____/_____ Reviewed by (initials): _____
Patient Signature *(required)* **Date** *(required)*

Educational needs (to be filled out by instructor, circle all that describe person)

☐ All categories
☐ Diabetes disease process ☐ Psychological adjustment ☐ Diabetes in pregnancy
☐ Blood sugar meter and goals ☐ Medications ☐ Goal setting and problem solving
☐ Nutritional management ☐ Short-term complications ☐ Long-term complications
☐ Physical activity (physical movement)

Instructor signature: _____ Date: _____