The Everett Clinic
Diabetes Self-Management Program

History

PT OR FIRM DIRECT #	FC
MONTH DAY YEAR	MD#
PT NAME: FIRST MI LAST	
ACCOUNT BILLED TO OR CARE OF	
ADDRESS	
CITY STATE ZIP	
EMPLOYER	
PHONE	

Please Tell Us About Yourself:

Name _____ **Age** _____ **Primary Care Physician** _____

Ethnicity (optional) _____

How long have you had diabetes? _____ ☐ **Type 1** ☐ **Type 2**

☐ **Gestational Diabetes** ☐ **Don't know**

Do you test your blood sugar level at home? No / Yes What brand meter? _____

How often do you test? _____ **Usual results:** _____

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 is low, 5 is 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 challenges with any of the following that may make learning difficult?

☐ **Vision** ☐ **Hearing** ☐ **Language** ☐ **Reading ability** ☐ **Other** _____

Medical History

Please circle all that apply:

Heart Disease	**Gestational Diabetes**	**Impotence**	**Sleep Apnea**
High Blood Pressure	**Foot Problems**	**Kidney Problems**	**Asthma**
High Cholesterol	**Neuropathy**	**Eye Problems**	**COPD/Emphysema**
Arthritis	**Thyroid Condition**	**Depression**	**High Triglycerides**
			Other:_____

Are you pregnant? ☐ **Yes** ☐ **No**
Do you plan to become pregnant in the future? ☐ **Yes** ☐ **No**

Do you smoke? ☐ **No** ☐ **Yes. Amount per day:** _____

Do you take vitamins or herbal supplements? [ ] No / [ ] Yes If yes, please list:	**List medications taken for Diabetes:**

Continued …

Exercise & Weight

Do you exercise regularly? ☐ **No / ☐ Yes. Type of exercise:** _____

Times per week: _____ **Minutes:** _____

Describe any exercise limitations: _____

Height: _____ **Weight:** _____ **What is your goal weight?** _____

Has your weight changed in the past three months? ☐ **Y** ☐ **N** **Was this intentional?** ☐ **Y** ☐ **N**

How many pounds did you lose _____ **OR gain** _____**?**

Schedule

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

Occupation _____ **Work hours:** _____

Is your work physical in nature? ☐ **Y** ☐**N**

Diet

Do you drink alcohol? ☐ **No /** ☐ **Yes. Amount:** _____ **Frequency:** _____

Do you drink milk? ☐ **None**

☐ **Non-fat / ☐ 1% / ☐ 2% / ☐ Whole / How much per day?** _____

Do you drink regular soda or fruit juice? ☐ **No /** ☐ **Yes.** **What kind?** _____ **How Much?** _____

How many servings of fruit do you eat daily? _____ **Vegetables?** _____

Are you following any special diet now? ☐ **No /** ☐ **Yes.** _____

Who does the food shopping and cooking at home? _____

How many meals per week do you eat out? _____

Types of restaurants most visited? _____

Please list what you eat in a typical day

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

Educational Needs (to be filled out by instructor)

☐ All categories

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

Instructor Signature _____ Date _____