Center for Nutrition & Diabetes Management

Diabetes and Nutrition Assessment

Name: ______________________________ **Date:** ____________________

What type of diabetes do you have? ☐ **Type 1** ☐ **Type 2**

The most important things I want to learn/concerns I have:

☐ manage my blood sugar
☐ use a blood sugar meter
☐ take better care of myself
☐ self administer insulin
☐ other: ___________________________________
☐ manage my weight
☐ eat healthy/follow healthy diet
☐ be consistent with exercise
☐ avoid complications
☐ plan meals
☐ portion control
☐ read food labels
☐ paying for supplies, medications or medical care

Health problems/Surgeries: ____

____

Height: _______ Weight: _______

Medications - List all **medications, vitamins, herbs and supplements** you are taking:

Name	Dose	When Taken	Taking it as prescribed? Yes/No

If not taking medications as prescribed, why not?
☐ forget ☐ side effects ☐ too expensive ☐ forget to renew
Other (please explain): ____

Do you take an aspirin daily? Yes (dose:__________) No
Medicine Allegies: ____
Food Allergies: ____
Have you had the following immunizations? Flu shot ☐ Pneumonia (at least once if over 65 years)

History

Family member had a heart attack (male younger than 55 or female younger than 65)
High blood pressure (greater than 130/80 mmHg)
Stress- Your level on a scale of 1 to 10: (10 = very high) : _______________
High Blood Cholesterol (greater than 200mg/dL)
☐ Family history of diabetes.

Living and Working Situation:

1. With whom do you live? Alone Spouse Family ☐ Friend ☐ Significant other
2. Do you have support in your diabetes management? If yes who: ______________________________
3. Are you currently employed? No Yes Type of Job: ______________________________
4. Are you are retired? No Yes What was your previous job? ______________________
5. Are you a student? No Yes

Exercise:

1. Do you exercise regularly? No Yes What kind of exercise do you do? __________________
2. How often: ____ For how long? ________________
3. Have you had an exercise stress test? No Yes When? ___________________________
4. Have you had an EKG? No Yes When? ___________________________

Sleep Problems:

1. Do you have any sleep problems? No Yes If yes, do you have:
   - Morning headaches
   - Periods of not breathing when sleeping
   - Feeling not rested and tired during the day
   - Restless sleeping
   - Snoring
   - Sleep deprivation due to partner's snoring
   - Trouble getting to sleep/insomnia
   - Sleep Apnea: ___use CPAP machine, ____ do not use

Learning Needs:

1. How do you like to learn? Reading Discussion Hands on training Role playing Internet Lecture Videos or DVDs
2. Education level? High school College Advanced degrees
3. Do you have and problems with hearing, vision or speech ? No Yes Explain: _______________

Feelings and Concerns:

1. How do you feel about having diabetes? Okay Anxious Angry Afraid Sad Depressed Overwhelmed Burned out Unsure of what to do ☐ Alone
   Other ____

Depression:

1. Have you recently felt down, depressed, hopeless or have little or no interest/pleasure in doing things?
   Yes No
2. Are you being treated for depression? Yes No

Pain Assessment:

1. Do you have a condition that causes pain? Yes ☐ No
2. If yes, is it being managed effectively by your doctor? Yes No Explain: __________________
3. How does the pain affect your diabetes? ____

Women's Health:

1. Are you of childbearing age? Yes No
2. Number of children: ____
3. Number of miscarriages/abortions: ____________________________
4. Have you had gestational diabetes? Yes No

Nutrition:

1. Have you ever struggled with? No Yes
   - ☐ Anorexia Bulimia ☐ Binge eating disorder ☐ Compulsive overeating
2. What have you done about this?

   ____
3. Do you have any problems with: Gums Problems chewing Dentures
4. Who prepares your meals for you?____
5. How many times a week do you eat away from home? ______________________________
   Fast food Restaurant Take out Other
6. Do you: Skip meals Nibble between meals Eat rapidly
   Have food cravings Use convenience foods Eat unplanned meals Other ________
7. What are your main beverages?____

Alcohol/Nicotine:

1. Do you drink alcohol? No Yes How much? _____________ How often?_____________
2. What do you drink? Light Beer Beer Wine Liquor
3. Do you use any nicotine products? Yes No
   If yes, Smoke cigarettes Chew tobacco cigars pipe
4. How much do you smoke? ____
5. If you stopped smoking/chewing, how long ago did you quit?______________________
6. If you have not stopped smoking/chewing, do you want to stop? Yes No

Diabetes History:

1. Have you ever had diabetes education? No Yes When? _________________________
2. Have you ever had nutrition education? ☐ No ☐ Yes When? _______________________
3. When were you diagnosed? ____
4. What are your symptoms of high blood sugar? None
   Hunger Thirst Frequent urination Dry skin
   Blurred vision Tired Frequent infections Erectile dysfunction
   Numbness/tingling in hands and feet Weight loss Ketoacidosis
5. Have you experienced any of the following?
   Tingling/numbness in feet/hands Constipation/diarrhea Blurred vision
   Frequent urinary tract infections ☐ Excessive sweating Sexual dysfunction
   Bloating/nausea with meals Dizziness when standing Uncontrolled blood pressure
   Frequent infections/slow healing wounds
6. Are there any religious or cultural factors that affect your diabetes? No Yes Explain: ______

   ____
7. Have you had any hospitalizations or emergency room visits because of your diabetes? Yes No
   If yes, describe ____
8. When was the last time you called your doctor about diabetes and what was it about? ____________

   ____
9. Last appointment with health care provider for diabetes: ___________________________
   Last eye exam: ___________________ Last dental exam: _________________________
   Last foot exam: ___________________

Insulin Use:

1. Do you take insulin? Yes No If yes: ☐ pen ☐ Syringe ☐ Pump
2. Who fills your insulin syringe? ___________ Who injects your insulin? ____________________
3. Where do you inject? Arm Abdomen Thigh Buttocks ☐ Other
4. Do you use a **continuous** glucose monitoring system? No Yes Type: ___________________
5. Where do you store your insulin? ____
6. Are you enrolled in the Community Safe Syringe Program? Yes No
7. Do you skip or adjust your insulin? Yes No
   If yes, why? Forgot to take it Can't afford insulin

Follow physician orders for adjustment — Ran out of insulin
Take more insulin when blood glucose is high — ☐ Other: ___________________
Take less insulin when blood glucose is low — _________________________

Self Monitoring Skills :

1. Do you check your blood sugar? Yes No
2. When do you test? ☐ Fasting ☐ Before meals ☐ After meals ☐ Bedtime ☐ Before driving
3. What kind of meter do you use? ____
4. What is your usual blood sugar range?
   - Most results within range (70 – 130mg/dL before meals, less than 180mg/dL after meals)
   - Most results out of range
5. Do you record your results? No Yes If yes, where: _________________________
7. What do you do if your blood sugar is high? Nothing Drink water Exercise Call my doctor
   Decrease food intake Increase insulin Increase diabetes medications
8. What do you do if you are sick? Nothing Stop taking diabetes medication Increase fluids
   Increase food intake Decrease food intake Call my doctor
9. Do you test for ketones? No Yes When? ____
10. Do you know what an A1c is? Yes ☐ No

Low Blood Sugar:

1. Have you ever had a low blood sugar? Yes No
2. What are your signs/symptoms of low blood sugar?
   Hunger Shakiness Sweating Anxiety Fast heartbeat Other ___________
   Dizziness Weakness Irritability vision change Headache
3. Why do you get low blood sugars? Too much insulin or oral medication Unexplained
   Skipped a meal/snack Increased exercise
4. What did you do to treat the low blood sugar? Nothing Called my doctor Ate lots of food
   Ate/drank food with fast acting sugar Went to the Emergency Room
5. Do you carry a source of sugar with you? No Yes What?_____________________________
6. Do you wear diabetes identification? No Yes What kind? _______________________
7. Do you have a glucagon kit? No Yes Expiration date: _______________________
   a. Does family/significant other know how to use it? Yes No

Is there anything else you would like the diabetes educator and registered dietitian to know? ____

____

Questions you want answered: ____

____

_________________________________ _____________
Patient Signature Date

_________________________________ _____________
Diabetes Educator Signature Date

_________________________________ _____________
Nutritionist Signature Date

Usual Weight: _______ Goal Weight: ________ Recent Gain or Loss: _______

Please record a "usual" day.
What kind of food? How much food?

BREAKFAST Time ________	**MORNING SNACK Time _______**
LUNCH Time _________	**AFTERNOON SNACK Time ______**
DINNER Time _________	**EVENING SNACK Time ________**

____, R.D. Date: _________________