

**Center for Nutrition and Diabetes Management
Diabetes and Nutrition Assessment**

Dear Patient,

This assessment will help us quickly learn about your diabetes education and nutrition needs. We appreciate the time you will take to complete this assessment. Thank you!

Name: _____

Date: _____

The most important things I want to learn are to:

- | | | |
|--|---|---|
| <input type="checkbox"/> manage my blood sugar | <input type="checkbox"/> manage my weight | <input type="checkbox"/> plan meals |
| <input type="checkbox"/> use a blood sugar monitor | <input type="checkbox"/> eat healthy | <input type="checkbox"/> learn more about carbohydrates |
| <input type="checkbox"/> take better care of myself | <input type="checkbox"/> read labels | <input type="checkbox"/> portion control |
| <input type="checkbox"/> self administer insulin | <input type="checkbox"/> nothing | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> avoid complications of diabetes | <input type="checkbox"/> everything | _____ |

Health Problems/Surgeries: _____

Medications

1. List all medications you are taking including over the counter medications, herbs and vitamins.

Name	Dose	When Taken

2. Do you take an aspirin daily? Yes No

3. Allergies - Medicine: _____

Food: _____

Immunizations:

Have you had the following immunizations? Flu (yearly)

Pneumonia (at least once if over 65 years of age) No

Risk Factors: Check all that apply:

- Family member had a heart attack (male younger than 55 or female younger than 65)
- High blood pressure (greater than 120/80 mmHg)
- Physical inactivity (exercising less than 30 minutes 3 or more days per week)
- Alcohol consumption (greater than 2 drinks a day)
- Stress- Your level on a scale of 1 to 10: (10 = very high) : _____
- Overweight/obese
- Diabetes
- High Blood Cholesterol (greater than 200mg/dL)
- Current Smoker

Living and Working Situation:

1. With whom do you live? Alone Spouse Family Friend(s) Significant Other
2. Who will support you in your diabetes management? No one Spouse Significant Other
 Son/daughter Friend(s) Family
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:

- Do you have any sleep problems? No Yes If yes, do you have:
- Morning headaches Snoring
 - Periods of not breathing when sleeping Sleep deprivation due to partner's snoring/restlessness
 - Not rested and tired during the day Trouble getting to sleep/insomnia
 - Restless sleeping 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. Do you have any trouble reading written information on diabetes? Yes No

3. Are you confident filling out medical forms independently? Yes No
4. Do you have and problems with hearing 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 _____
2. What are your concerns about diabetes? Nothing
- | | | |
|---|---|--|
| <input type="checkbox"/> Following a healthy meal pattern | <input type="checkbox"/> Fear over diagnosis | <input type="checkbox"/> Paying for medications/supplies |
| <input type="checkbox"/> Being consistent with exercise | <input type="checkbox"/> Becoming pregnant | <input type="checkbox"/> Lack of insurance |
| <input type="checkbox"/> Checking blood sugar | <input type="checkbox"/> Depression | <input type="checkbox"/> Coping |
| <input type="checkbox"/> Giving self injections | <input type="checkbox"/> Anger over diagnosis | <input type="checkbox"/> Learning all the information |
| <input type="checkbox"/> Work/family schedule | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Don't think I have diabetes |
| <input type="checkbox"/> Complications of diabetes | <input type="checkbox"/> Losing weight | <input type="checkbox"/> Physical problems |
| <input type="checkbox"/> Sexual function/issues | <input type="checkbox"/> Lack of support system from family/friends | |
| <input type="checkbox"/> Not being successful with plan | <input type="checkbox"/> Other: _____ | |

Depression:

1. Are you being treated for depression? Yes No
2. Have you recently felt down, depressed, hopeless or have little or no interest/pleasure in doing things?
 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. If pregnant, due date: _____
3. Number of children: _____
4. Number of miscarriages/abortions: _____
5. Have you had gestational diabetes? Yes No

Nutrition:

1. Height: _____ Weight: _____
2. Do you need help with your diet? No Yes

3. Have you seen a nutritionist? No Yes When? _____
4. Are there any religious or cultural factors that affect how you eat? No Yes
Explain: _____
5. Do you have or have you ever been treated for an eating disorder? No Yes
 Anorexia Bulimia Binge eating disorder
6. Are you uncomfortable eating in social situations? Yes No
7. Do you feel deprived regarding food and meals? Yes No
8. Do you feel constantly concerned about food and eating? Yes No
9. Do you have any problems with: Gums Problems chewing Dentures
10. Who prepares your meals for you? _____
11. How is your food usually prepared? Fried Baked Grilled Broiled Other _____
12. How many times a week do you eat away from home? _____
 Fast food Restaurant Take out Other
13. Do you: Skip meals Nibble between meals Eat rapidly
 Have food cravings Use convenience foods Eat unplanned meals Other _____
14. How many servings of the following do you eat daily? Milk/yogurt _____
Vegetables _____ Fruits _____
Meat/beans/cheese _____ Water _____
15. What are your main beverages? _____

Alcohol/Nicotine:

1. Do you drink alcohol? No Yes How much? _____
2. What do you drink? Light Beer Beer Wine Liquor
3. How often do you drink? Daily Socially Weekends only
 Several times a week Weekly Several times per month Monthly
4. Do you use any nicotine products? Yes No
If yes, Smoke cigarettes Chew tobacco Use nicotine gum/lozenges/patch
5. How much do you smoke? _____
6. If you stopped smoking/chewing, how long ago did you quit? _____
7. If you have not stopped smoking/chewing, do you want to stop? Yes No
How do you plan on doing it? _____

Diabetes History:

1. Have you ever had diabetes education? No Yes When? _____
2. What type of diabetes do you have? _____
3. When were you diagnosed? _____

4. What are your symptoms of high blood sugar? None
- | | | | |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> Hungry | <input type="checkbox"/> Thirsty | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Tired | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Numbness/tingling in hands and feet | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Ketoacidosis | |
5. Is there a family history of diabetes? No Yes If yes, who? _____
6. Do you have any problems such as:
- | | | |
|--|--|--|
| <input type="checkbox"/> Tingling/numbness in feet/hands | <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Blurred vision |
| <input type="checkbox"/> Frequent infections/slow healing wounds | <input type="checkbox"/> Frequent urinary tract infections | |
| <input type="checkbox"/> Bleeding or infected gums | <input type="checkbox"/> Bloating/nausea with meals | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Uncontrolled blood pressure | <input type="checkbox"/> Sexual activity | <input type="checkbox"/> Dizziness when standing |
| <input type="checkbox"/> Heart disease _____ list | | |
7. Are there any religious or cultural factors that affect your diabetes? No Yes Explain: _____
8. If sexually active, are you practicing safe sex and using birth control? Yes No
9. Have you had any hospitalizations or emergency room visits because of your diabetes? Yes No
If yes, describe _____
10. When was the last time you called your doctor about diabetes and what was it about?

11. Do you feel comfortable discussing your concerns with your doctor?
 Yes No If no, why? _____
12. Last diabetes check up: _____
Last eye exam: _____ Last dental exam: _____
Last foot exam: _____ Last EKG: _____

Insulin Use:

1. Do you take insulin? Yes No
2. Who fills your insulin syringe? _____ Who injects your insulin? _____
3. Where do you inject? Arm Abdomen Thigh Buttocks
4. Do you use an insulin pen? No Yes Type: _____
5. Do you use an insulin pump? No Yes Type: _____
6. Do you use a continuous glucose monitoring system? No Yes Type: _____
7. Where do you store your insulin? _____
8. Are you enrolled in the Community Safe Syringe Program? Yes No
9. 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 Don't like to take too much insulin
 Take less insulin when blood glucose is low

Self Monitoring Skills :

1. Do you check your blood sugar? Yes No
2. What kind of meter do you use? _____
3. What is your usual blood sugar range?
 Most results within range (90 – 130mg/dL before meals, Less than 160mg/dL after meals)
 Most results out of range
4. Do you record your results? No Yes
5. When do you check your blood sugar? Fasting Before meals After meals Bedtime 3AM
6. 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
7. What do you do if you are sick? Nothing Stop taking diabetes medication Increase fluids
 Increase food intake Decrease food intake Call my doctor
8. Do you test for ketones? No Yes When? _____
9. 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 Blurred vision 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 or 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 nutritionist to know? _____
-

Patient Signature

Date

Diabetes Educator Signature

Date

Nutritionist Signature

Date

Height: _____ Weight: _____ Usual Body Weight: _____ Goal Weight: _____
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: _____