Demographic Information		
Email address		
Home Phone	Cell Phone	Sex □ Male □ Female
Work Phone	Occupation	Marital Status □ S □ M □ W □ D
Name of Referring Physician:	Name of Family Physician	
General Medical Information		
Are you allergic to any medications, please list them:	Other allergies, please list them:	
List any past illnesses and dates of the illness	Past surgeries and dates of surgery:	
Are you aware of the complications that may develop when you have diabetes? □ Yes □ No		

Please mark if you have or have had any of the following:

Thyroid Disease	□ Yes	□ No	
Heart Disease	□ Yes	□ No	
High Blood Pressure	□ Yes	□ No	
High Cholesterol/Triglycerides	□ Yes	□ No	
Eye/Vision problems	□ Yes	□ No	Date of last eye exam: ___________________
Kidney problems	□ Yes	□ No	
Bladder problems	□ Yes	□ No	
Dental/Mouth problems	□ Yes	□ No	Date of last dental exam: _________________
Liver disease	□ Yes	□ No	
Foot problems	□ Yes	□ No	
Do you check your feet daily?	□ Yes	□ No	
Circulation problems	□ Yes	□ No	
Numbness or pain in hands, feet, or legs	□ Yes	□ No	
Difficulty with sexual function	□ Yes	□ No	
Slowed stomach emptying	□ Yes	□ No	
Stroke	□ Yes	□ No	
Depression	□ Yes	□ No	Treatment: _____________________________
Any other medical conditions?	□ Yes	□ No	List: __________________________________ ____
Have you ever been told you have sleep apnea?	□ Yes	□ No	
If yes, do you use a CPAP machine?	□ Yes	□ No	
If female do you use contraception?	□ Yes	□ No	If yes, what type? _______________________

Have you experienced episodes of:

□ Diabetic ketoacidosis	□ Yes □ No	
□ High blood sugar (250 or more)	occurs about _________	times a week/month/year
□ Low blood sugar (70 or less)	occurs about _________	times a week/month/year
□ Ketones in urine	occurs about _________	times a week/month/year
□ Hospitalization due to diabetes	occurs about _________	times a year.

______________________________ ______________________________

Diabetes Educator Date

RN3890

Mary Washington Hospital
MEDICORP

Outpatient Diabetes Health History Record

FR-1184-MWH Rev 12/2008

PATIENT IDENTIFICATION
1 1/4" X 3"

Diabetes History

Type: □ Type 1 □ Gestational □ Type 2 □ Other	Date of Diabetes Diagnosis:	How did you learn you have diabetes?

Treatment: □ Diet/Exercise □ Byetta □ Oral (pills) □ Symlin □ Insulin □ ______	Name of insulin or oral drug	Dose	Side Effects

Do you monitor blood sugars? □ Yes □ No	Which meter?	How often/time of day?	Usual readings?	Do you record results? □ Yes □ No

Do you have a family history of diabetes? □ Mother □ Father □ Siblings □ Other	Time lost from work or school in the past year due to diabetes? □ Yes □ No How many days? ______________________

Pain Assessment

Do you have any chronic pain? □ Yes □ No	If yes, where located?	Duration of pain?	Any treatment?

How would you rate the pain? 1 2 3 4 5 6 7 8 9 10 (10 is the worst and 1 is the least)
Describe:

Physical Activity Habits

Regular Exercise Program? □ Yes □ No	Type:	Duration:

Education History

Highest level of education completed □ Grade School □ High School □ College	Problem with learning? □ Yes □ No	If Yes, Describe:
Have you had any diabetes education before? □ Yes □ No	If yes, when and where?	Did friend/family participate? □ Yes □ No

Social History

Do you smoke? □ Yes □ No	If yes, what type and how much?	Are you interested in smoking cessation? □ Yes □ No
Do you drink alcohol? □ Yes □ No	If yes, what type?	If yes, how much?
How many people live in your home?	What are their relationships to you?	

Do you use community resources? (example: Health Department, Rappahannock Community Services Board) □ Yes □ No List: ___________________________	Do you get a yearly flu shot? □ Yes □ No Have you ever had a pneumonia shot? □ Yes □ No

Do you have any special cultural needs?

Health Belief/Goals/Attitudes

Feelings about your health and diabetes?

Rate your health: □ excellent □ good □ fair □ poor

Do you feel: Diabetes is serious? □ Yes □ No	Do you feel: You can control your diabetes? □ Yes □ No

I want to learn more about: □ Diet □ Exercise □ Preventing complications of diabetes □ Stress Management
□ How to test my blood sugar □ Tests to take regularly and target values □ Other: ______________________

For Office Use Only: Height: _______________ Weight: _______________ Usual Weight: ___________
The above information has been reviewed and learning needs have been identified.
Comments:

_____________________________________ _____________________________________
Diabetes Educator Date

RN3890

Mary Washington Hospital
MEDICORP

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