

DIABETES MANAGEMENT
5008 SOUTHPOINT PARKWAY
FREDERICKSBURG, VA 22407

PHONE: 540-741-2210
FAX: 540-741-2211

INSTRUCTIONS

Please provide the information requested in PART I and III; this information will help us serve you better. You may leave blank any areas of which you are uncertain and the Diabetes Educator will review the information with you during your session.

PART I - TO BE COMPLETED BY PATIENT.

DEMOGRAPHIC INFORMATION

NAME	ADDRESS	STREET	CURRENT DATE
HOME PHONE	CITY, STATE, ZIP	OCCUPATION	RACE
WORK PHONE	SOCIAL SECURITY	DATE OF BIRTH	
MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	NAME OF REFERRING PHYSICIAN	NAME OF FAMILY PHYSICIAN	

GENERAL MEDICAL INFORMATION

IF YOU ARE ALLERGIC TO ANY MEDICATIONS, PLEASE LIST THEM.	IF YOU HAVE OTHER ALLERGIES, PLEASE LIST THEM.
PLEASE LIST ANY CHRONIC ILLNESS AND DATE OF DIAGNOSIS	PLEASE LIST DATE/TYPE OF PAST SURGERIES.
PREScribed MEDICATIONS BY MD	OVER THE COUNTER MEDICATIONS
HIGH BLOOD PRESSURE <input type="checkbox"/> YES <input type="checkbox"/> NO	

PART II - TO BE COMPLETED BY DIABETES EDUCATOR



HEIGHT	WEIGHT	PRE-PREGNANCY WT	EDC	<input type="checkbox"/> SINGLE BIRTH <input type="checkbox"/> MULTIPLE BIRTH
PAST HISTORY OF GESTATIONAL DIABETES: <input type="checkbox"/> YES <input type="checkbox"/> NO GRAVIDA/PARA _____/____	DELIVERY GOALS: <input type="checkbox"/> NATURAL BIRTH <input type="checkbox"/> MEDICATION POST PARTUM GOALS: <input type="checkbox"/> BREASTFEED <input type="checkbox"/> BOTTLEFEED <input type="checkbox"/> COMBINATION	CHILD #1 BIRTH WT _____ <input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL	CHILD #2 BIRTH WT _____ <input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL	CHILD #3 BIRTH WT _____ <input type="checkbox"/> C-SECTION <input type="checkbox"/> VAGINAL
COMMENTS:				



Mary Washington Hospital
 MEDICORP

Outpt Diab Mgmt Record (Pregnant Patient)
 FR-1184A-MWH – REV. 5/2007

PATIENT IDENTIFICATION
 1 1/4" X 3"

Diabetes History		Part III - To Be Completed By Patient		
Type <input type="checkbox"/> Type 1 <input type="checkbox"/> Gestational <input type="checkbox"/> Type 2 <input type="checkbox"/> Other		Length of time since diagnosis		If recently, signs and symptoms
Treatment <input type="checkbox"/> Diet/Exercise <input type="checkbox"/> Oral (pills) <input type="checkbox"/> Insulin		Name of insulin or oral drug	Dose	Side Effects
Monitor Blood Sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No	Which meter?	How often/time of day?	Usual readings	Do you record results? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have family history of diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling <input type="checkbox"/> Other			Time lost from work or school in the past year due to diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days?	
Pain Assessment				
Do you have any chronic pain? <input type="checkbox"/> Yes <input type="checkbox"/> 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				
Any restrictions for activity by MD: <input type="checkbox"/> Yes <input type="checkbox"/> No		Regular exercise program: <input type="checkbox"/> Yes <input type="checkbox"/> No		Type and Duration:
Education History				
Level of Education <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College		Problems with learning? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, describe
Have you had any diabetes education before? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when and where?		Did friend/family participate? <input type="checkbox"/> Yes <input type="checkbox"/> No
Note to Diabetes Educator: Document previous education on Diabetes Management Protocol				
Social History				
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have an eating disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, is your physician aware? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you use community resources? (example -Health Department, Rappahannock Community Services Board) <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, which ones?	
How many people live in your home?			What are their relationships to you?	
Hygiene Patterns				
Do you see a dentist once per year? <input type="checkbox"/> Yes <input type="checkbox"/> No			Do you see an eye doctor once a year? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you practice some form of contraception when not pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Health Belief/Goals/Attitudes				
Feelings about your health and diabetes?				
Areas of interest/concern for education session?				
Signature of Diabetes Educator			Date	
 RN 4705		 Mary Washington Hospital MEDICORP		PATIENT IDENTIFICATION 1 1/4" X 3"
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