State of Franklin HEALTHCARE ASSOCIATES
Your Health, Our Focus

IDX#_____

Johnson City Internal Medicine
301 Med Tech Parkway, Suite 240, Johnson City, TN 37604 (423)794-5823

SoFHA Diabetes Clinic Assessment

Instructions: Please complete and bring to your appointment with Dr. Rick Hess on _____.

PLEASE ALSO BEGIN TO CHECK SUGAR REGULARLY AT LEAST 7 DAYS BEFORE YOUR APPOINTMENT & BRING YOUR GLUCOSE METER/DIARY FOR DOWNLOAD.

General Information

1. Name:_____Date of birth:_____Email:_____
2. Address:_____
3. City:_____State:_____Zip:_____
4. Home Phone:_____Work Phone:_____
5. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
6. How many people live in your household? _____
7. Is there anyone who will help you with your diabetes care? ☐ Yes ☐ No
   If yes, who?_____
8. Occupation:_____Work hours:_____
9. Education: ☐ Some High School ☐ High School Graduate
   ☐ Some College ☐ College Graduate
   ☐ Post-graduate ☐ I prefer not to answer

Diabetes History

1. How long have you had diabetes?_____
2. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Don't know
3. List any family members with diabetes:_____
4. In your own words, what is diabetes?
5. How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor
6. Have you ever been instructed on diabetes care? ☐ Yes ☐ No
   If yes, when and with whom? _____
7. What are the areas of diabetes would you like to learn about (check all that apply)?
   ☐ What is diabetes? ☐ Nutrition ☐ Pregnancy with diabetes
   ☐ Medications ☐ Exercise ☐ Blood testing
   ☐ High blood sugar ☐ Stress ☐ Complications
   ☐ Low blood sugar ☐ Sick days ☐ Insulin
8. How do you feel about having diabetes? _____
9. My diabetes has caused a problem in the following areas (check all that apply):
   ☐ Family life/social activities ☐ Work/school ☐ Sports/exercise
   ☐ Sexual relations ☐ Finances ☐ Travel
   Other _____
10. How do you learn best? ☐ Written materials ☐ Discussion ☐ Video

11. What is your goal for these educational sessions (check all that apply)?
    □ Learn more about diabetes □ Help with meal planning
    □ Better blood sugar control □ Weight management
    Other:_____

Nutrition

1. Height:_____Weight:_____What weight are you comfortable at?_____
2. Has your weight changed in the past 3 months? □ Yes □ No
   If yes, I've □ lost / □ gained _____ lbs.
   Was the weight change intentional? □ Yes □ No
3. Have you ever received diet counseling? □ Yes □ No
   If yes, describe:_____
4. How many times do you eat per day?_____Meals?_____Snacks?_____
5. Who does the cooking?_____
6. How many times/week do you eat away from home?_____
   How often is your meal away from home:
   Cafeteria style?_____Fast Food?_____Buffet?_____
   Sit-down restaurant?____Other? _____
7. How is your food usually prepared? □ Fried □ Baked □ Broiled □ Grilled
8. How would you describe your food portions? □ Small □ Average □ Large
9. List any food allergies or intolerance:_____
   _____
10. List any special diet needs:_____
    _____
11. How does moods/stress affect your eating?_____
    _____
12. Have you ever been told you have high cholesterol? □ Yes □ No
13. Have you ever been told you have high triglycerides? □ Yes □ No
14. Have you ever been told you have high blood pressure? □ Yes □ No

24 hour food recall (include amount and how prepared)		
Breakfast – Time?	Lunch – Time?	Dinner – Time?
Snack –Time?	Snack – Time?	Snack – Time?

Which nutritional issue(s) are you most concerned about when managing diabetes?

What barriers do you believe will cause the most problems for you?

Medication

1. If you take insulin:
   Do you inject with: □ syringe? □ insulin pen? □ insulin pump?
   Who fills the syringe?_____Who gives the injection?_____
   What injection sites are used?
   Where do you store your insulin?

   Do you reuse your syringes? □ Yes □ No If yes, how often?
   Where do you dispose of your syringes? _____
2. Do you take pills for diabetes? □ Yes □ No
   If yes, what is the name of the medication(s)?_____
   _____
   How often do you take the medication(s)? _____
   List any side effects you experience:_____
3. Have you ever forgotten to take your diabetes medication? □ Yes □ No
   If yes, what did you do? _____

Monitoring

1. Do you test your blood sugar? □ Yes □ No
   If yes, what blood sugar monitor do you use? _____
   How often do you test?_____Usual result:_____
   Do you keep a record/logbook? □ Yes □ No
2. Do you test your urine for ketones? □ Yes □ No
   If yes, how often do you test?_____Usual result:_____

Exercise

1. Do you exercise regularly? □ Yes □ No
   If yes, what type of exercise(s)? _____
   How often do you exercise? _____
   How long do you exercise?_____What time of the day?_____
2. List any problems with exercise:_____
   _____

Acute Complications

1. Have you ever had a low blood sugar reaction? □ Yes □ No
   If yes, how did you feel? _____
   How did you treat it? _____

2. Do you carry a source of sugar with you? □ Yes □ No
3. Have you ever be given glucagon? □ Yes □ No

4. Do you have a glucagon kit? □ Yes □ No
   Does someone you live with know how to give glucagon?
   □Yes □ No □ Don't know
5. Have you ever had high blood sugar? □ Yes □ No □ Don't know
   If yes, how did you feel? _____
   What did you do to treat it? _____
   What do you consider a normal blood glucose range? _____

Long-Term Complications

1. Are you aware that complications may develop when you have diabetes?
   □ Yes □ No
2. Do you have any of the following complications now (check all that apply & explain)?
   □ Eye problems_____
   □ Heart problems_____
   □ Kidney problems_____
   □ Gastrointestinal problems_____
   □ Numbness/pain in extremities_____
   □ Sexual problems_____
3. Do you take an aspirin each day for heart disease protection? □ Yes □ No

Medical History

1. When was your last physical exam?_____
2. How often have you had your eyes checked?_____Date of last exam:_____
3. Have you noticed any changes in your skin lately? □ Yes □ No
   If yes, please describe:_____
4. How often do you check your feet?_____
5. How often do you have a dental checkup?_____Date of last checkup:_____
6. How would you describe your general health? □ Good □ Fair □ Poor
7. Is your health important to you?
   □ All the time □ Sometimes □ Only when ill □ No
8. Do you smoke?_____If yes, how much?_____
9. Do you drink alcohol?_____If yes, amount and type?_____
10. Have you been hospitalized in the past 6 months? □ Yes □ No
    If yes, describe reasons:_____
11. Have you been to the ER in the past 6 months? □ Yes □ No
    If yes, describe reasons:_____
12. Do you wear a medical identification bracelet or necklace? □ Yes □ No
13. Have you ever had a "pneumonia" shot? □ Yes □ No
14. Do you receive the "flu" shot each year? □ Yes □ No

Stress

1. Is there much stress in your life? □ Yes □ No
   If yes, explain:_____
2. What do you do to handle stress in your life?_____
   _____

Cultural Influences

1. Do you have any special dietary needs, religious and/or observances? □ Yes □ No
   If yes, explain:_____
2. Is English your second language? □ Yes □ No
   If yes, what is your language of preference? _____

Pregnancy

1. Are you currently pregnant? □ Yes □ No Due Date:_____
2. Are you planning on becoming pregnant? □ Yes □ No

Notes/Comments

For Educator Use Only – Do Not Write

Educational Need Assessment:

□ Diabetes Introduction	□ Acute Complications	□ Healthy Food Choices
□ Chronic Complications	□ Physical Activity	□ Diagnosis/Goal Setting
□ SMBG	□ Medications/Insulin	□ Diabetes and Emotions

Comments:_____
_____
_____
_____
_____
_____

_____
Educator Signature Date