Lexington Clinic

Diabetes Self Management Education
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

DIABETES SELF MANAGEMENT EDUCATION INITIAL PATIENT ASSESSMENT FORM

Name _____

Race ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

Preferred Language _____ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many people live with you? _____ Adults _____Children

Education Level ☐ High School Diploma ☐ Associate's Degree ☐ Bachelor's Degree
☐ Master's Degree ☐ PhD ☐ Other _____

Occupational Status ☐ Professional ☐ Manual Labor ☐ Retired ☐ Unemployed ☐ Student ☐ Disabled

How many hours per week are you involved in work/school activities?

☐ Less than 10 hours ☐ 11 - 20 hours ☐ 21 - 30 hours ☐ 31 - 40 hours ☐ More than 40 hours

How do you learn best?

☐ Individual Instruction ☐ Group Instruction ☐ Reading Materials ☐ Video

Do you have any problems with the following?

Seeing ☐ Yes ☐ No **Hearing** ☐ Yes ☐ No **Reading** ☐ Yes ☐ No

MEDICAL HISTORY

Condition	Please Explain
☐ Heart Disease	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Stroke	
☐ Circulation Problems	
☐ Kidney Problems	
☐ Lung Disease/Asthma	
☐ Depression	
☐ Foot Problems	
☐ Thyroid Disease	
☐ Eye Disease	
☐ Cancer	

Lexington Clinic

Diabetes Self Management Education
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

DIABETES SELF MANAGEMENT EDUCATION INITIAL PATIENT ASSESSMENT FORM *(continued)*

Do you use tobacco? ☐ Yes ☐ No **If yes, how much?** _____ **# of years?**_____

Do you drink alcohol? ☐ Yes ☐ No **If yes, what type?** _____ **# of drinks per week?** _____

Please list any medications you are currently taking

Name of Medication	Reason	Dose	Times Taken

Compared to others your age, how would you say your health is?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

NUTRITION

Do you currently pay attention to your food choices or follow an eating plan? ☐ Yes ☐ No

What type of special meal plan do you follow?_____

_____

Has your weight changed in the past year? ☐ Yes ☐ No **If yes, how much?** Gained _____ Lost _____

What is your desired body weight? _____

Have you ever participated in a weight loss program? ☐ Yes ☐ No

If yes, please explain _____

_____

Do you currently take any vitamin/mineral/herbal supplement? ☐ Yes ☐ No

If yes, please list _____

_____

Please list any cultural diet influences that you currently follow

_____

_____

Do you have any trouble chewing/swallowing foods? ☐ Yes ☐ No

Who prepares your meals daily? _____

How many times per day do you eat? _____

How many times per week do you eat out? _____ **Where?** _____

What would you say is the biggest challenge that you have with your diet?

_____

_____

Lexington Clinic

Diabetes Self Management Education
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

DIABETES SELF MANAGEMENT EDUCATION INITIAL PATIENT ASSESSMENT FORM (continued)

24 HOUR DIET RECALL

Please list everything that you remember eating in the past 24 hours. Please list time, food and the amount that you ate.

Breakfast (time:)	Lunch (time:)	Dinner (time:)	Snacks (time:)

PHYSICAL ACTIVITY

Are you currently involved in an activity/exercise program? ☐ Yes ☐ No

If yes, please describe _____

_____

How many minutes do you spend per day participating in exercise? _____

How would you rate your physical activity level?

☐ Inactive: *No regular physical activity*
☐ Light: *No regular physical activity, with 3-4 hours of walking or standing each day*
☐ Moderate: *Occasional weekend physical activity such as housework/yard work*
☐ Heavy: *Consistent physical activity such as lifting, heavy construction or active sports like cycling or jogging, 3 times per week*
☐ Vigerous: *Intense physical activity for at least 45 minutes greater than 4 times per week*

Lexington Clinic

Diabetes Self Management Education
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

DIABETES SELF MANAGEMENT EDUCATION INITIAL PATIENT ASSESSMENT FORM (continued)

DIABETES HISTORY

What type of diabetes do you have?
- ☐ Type I
- ☐ Type II

Do you have a family history of diabetes?
- ☐ Yes
- ☐ No

Have you received any type of diabetes education in the past?
- ☐ Yes
- ☐ No

If yes, when/where? _____

_____

How would you rate your understanding of diabetes and its treatment?
- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Are you currently checking your blood glucose at home?
- ☐ Yes
- ☐ No

How often do you check your blood glucose at home?
- ☐ Never
- ☐ Daily, _____times per day
- ☐ Weekly, _____times per week
- ☐ Monthly, _____times per month

Are you currently testing your urine for ketones?
- ☐ Yes
- ☐ No

If yes, when do you test? _____

_____

Does checking your blood glucose at home help you control your diabetes?
- ☐ Yes
- ☐ No

How often do you have low blood glucose (less than 70 mg/dL)?
- ☐ Never
- ☐ Sometimes
- ☐ Often

How often do you have high blood glucose (greater than 180 mg/dL)?
- ☐ Never
- ☐ Sometimes
- ☐ Often

Do you wear or carry diabetes identification?
- ☐ Yes
- ☐ No

How many times in the past year have you been in the hospital for your diabetes? _____

Do you carry a source of fast acting glucose in case of low blood sugar?
- ☐ Yes
- ☐ No

How often do you check your feet for signs of problems?
- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Never

How often do you see an ophthalmologist for a dilated eye exam?
- ☐ Never
- ☐ 1x/year
- ☐ 2x/year

Do you have any of the following diabetes complications?
- ☐ Eye problems
- ☐ Kidney problems
- ☐ Foot problems
- ☐ Heart vessel disease

How often do you miss work/school/household duties because of diabetes?
- ☐ Never
- ☐ Sometimes
- ☐ Often

Lexington Clinic

Diabetes Self Management Education
1221 South Broadway | Lexington, KY 40504
Phone: 859.258.4032

DIABETES SELF MANAGEMENT EDUCATION INITIAL PATIENT ASSESSMENT FORM (continued)

CURRENT HEALTH SERVICES

Do you get flu shots? ☐ Yes ☐ No

*If yes, date of last flu shot*_____

Have you ever had a pneumonia vaccination? ☐ Yes ☐ No

*If yes, date of last pneumonia shot*_____

Date of last dental exam _____ Date of last eye exam _____ Date of last diabetes foot exam _____

SOCIAL/EMOTIONAL

How does having diabetes make you feel? *(ex: okay, sad, depressed, overwhelmed)*

_____

_____

Do you have difficulty paying for your diabetes supplies? ☐ Yes ☐ No

Who do you consider to be your support person?

What would you say is your biggest challenge to caring for your diabetes?

_____

_____

What would you say is your personal strength to helping you with this challenge?

_____

_____

What possible barriers do you have in your life to prevent you from overcoming your challenges with your diabetes?

_____

_____

How would you rate your level of stress?

☐ Low ☐ Moderate ☐ High ☐ Very High

INDIVIDUAL EDUCATION PLAN

What topics are you especially interested in learning about to help you improve management of your diabetes?

☐ Understanding diabetes
☐ Blood glucose monitoring
☐ Increasing physical activity
☐ Healthy eating with diabetes
☐ Healthy coping with diabetes
☐ Medications, insulin injections
☐ Reducing risks of diabetes complications
☐ Treatment of diabetes complications

Patient Signature _____ Date _____