Northwestern Medicine®

Diabetes Assessment

Patient information

Name: ______________________ Date: ______________

Phone: ______________ Cell: ______________ Work: ______________

Appointment: ______________

Diabetes history

How long have you had diabetes? ______________________

What type of diabetes do you have? . . . . ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Do not know

Has anyone taught you how to care for your diabetes? . . . . ☐ Yes ☐ No

If yes, when and by whom? ______________________

What is your hemoglobin A1c? ______________ ☐ Do not know

Medications

List any medications, supplements or herbs you take.

Name	Dose	Time you take it

If you take insulin:

Do you inject insulin with: . . . . ☐ a syringe ☐ an insulin pen ☐ an insulin pump

Have you ever forgotten to take your diabetes medication? . . . . ☐ Yes ☐ No

If yes, what did you do? ______________________

Blood sugar monitoring

Do you test your blood sugar? . . . . ☐ Yes ☐ No

If yes, how many times do you test per day? ______________________

Usual results: Fasting ________ Before meals ________ 2 hours after meals ________ Bedtime ________

Do you keep a record? . . . . ☐ Yes ☐ No

Do you test your urine for ketones? . . . . ☐ Yes ☐ No

If yes, how often do you test for ketones? ______________ Usual results ______________

Acute complications

Have you ever had a low blood sugar reaction? . . . . . . ☐ Yes ☐ No

How did you treat it? ______

Have you ever had a high blood sugar reaction? . . . . . . ☐ Yes ☐ No

How did you treat it? ______

Chronic complications

Do you have any of the following complications?

☐ Eye problems ☐ Kidney problems ☐ Gastrointestinal problems ☐ Frequent infections
☐ Heart problems ☐ Numbness/pain ☐ Sexual problems ☐ Other

Medical history

When was your most recent physical examination by primary care provider? ______

How often do you have your eyes checked? ______ Date of last eye exam: ______

Have you noticed any changes in your skin recently? . . . . . . ☐ Yes ☐ No

If yes, please describe: ______

How often do you check your feet? ______ Date of last foot exam by physician: ______

How often do you have dental checkups? ______ Date of last dental visit: ______

Do you currently smoke? Or have you ever smoked? . . . . . . ☐ Yes ☐ No

If yes, for how long? ______ Cigarettes per day: ______ Quit date: ______

Do you have trouble sleeping? . . . . . . ☐ Yes ☐ No

If yes, please explain: ______

How often do you drink alcohol?

☐ Never ☐ Once a month or less ☐ 2 to 4 times a month
☐ 2 or 3 times a week ☐ 4 or more times a week

How many drinks do you have on a typical day when you are drinking?
(A standard drink is a 12-ounce can of beer; a 5-ounce glass of wine; or a 1½-ounce shot of liquor.)

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

Have you been hospitalized within the last 6 months? . . . . . . ☐ Yes ☐ No

If yes, explain why: ______

Have you been to the emergency department within the last 6 months? . . . . . . ☐ Yes ☐ No

If yes, explain why: ______

Are you currently under the care of other physicians? . . . . . . ☐ Yes ☐ No

If yes, explain why: ______

Do you have any non-food allergies? . . . . . . ☐ Yes ☐ No

If yes, explain: ______

Nutrition

Have you ever followed a meal plan? . . . . . ☐ Yes ☐ No

If yes, how many calories? ____________

How many times do you eat per day? Number of meals ____________ Number of snacks ____________

Who does the cooking? ____________

How many times a week do you eat away from home? ____________

How would you describe your appetite? . . . . . ☐ Good ☐ Fair ☐ Poor

How does your mood or stress affect your eating? ____________

Do you: ☐ Eat unplanned meals ☐ Nibble between meals ☐ Have food cravings
☐ Skip meals ☐ Use convenience foods ☐ Eat quickly

List any food allergies / intolerances: ____________

Do you have any special dietary needs or religious observances? . . . . . ☐ Yes ☐ No

If yes, please explain: ____________

Stress

Is there much stress in your life? . . . . . ☐ Yes ☐ No

If yes, explain: ____________

Exercise

Are you physically active? . . . . . ☐ Yes ☐ No

If yes, what type of exercise?: ____________

How often? ____________ How long? ____________

Health beliefs / goals / attitudes

How would you describe your general health? . . . . . ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate how well you understand diabetes? . . . . . ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is your health important to you? . . . . . ☐ All the time ☐ Sometimes ☐ Only when ill ☐ Not at all

Diabetes has affected the following parts of my life:

☐ Family life / social activities ☐ Work / school ☐ Sports / exercise ☐ Sexual relations
☐ Finances ☐ Travel ☐ Other ____________

How do you feel about having diabetes? ____________

____

____

Have you ever been diagnosed with depression? . . . . . ☐ Yes ☐ No

If yes, have you received treatment? . . . . . ☐ Yes ☐ No

What areas of diabetes would you like to learn more about?

☐ Diabetes basics	☐ Diet	☐ Pregnancy and diabetes	☐ Sick days
☐ High blood sugar	☐ Exercise	☐ Blood sugar testing	☐ Insulin pumps
☐ Low blood sugar	☐ Stress	☐ Complications	☐ Pills for diabetes

Thank you for taking the time to complete this form.

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