

**University of South Florida Diabetes Center
Adult Diabetes Education Assessment Record**

Date: _____ Date of Birth: _____ Age: _____
Name: _____ Email address: _____
Address: _____ Initial if we may email diabetes info _____
City: _____ Phone: H _____
State: _____ W _____
Zip: _____ Other _____
Physician Name _____ Physician Address _____

Statistical Data: Sex: M____ F____
Ethnic Group (check all that apply):
African American ____ Asian/Pacific Islander ____
Hispanic ____ Caucasian ____
Native American ____ Other Group (specify) _____
Marital status: Single____ Married/Partnered ____ Divorced ____ Widowed ____
Highest grade completed: _____ **Living alone** ____ **or with others** ____

The ways you learn best: **Problems with reading/learning?** Y____ N____
Discussion____ If yes, what are they? _____
Reading ____
Lecture____ **Barriers/Difficulties:** Complete only what applies
Video/TV/Computer____ Visual _____
Hands On ____ Hearing _____
Other _____

Your Diabetes Is: **Were you taught to take care of diabetes?**
Type 1____ Yes: ____ No: ____
Type 2 ____ If yes, when? _____
Gestational ____ By whom? _____
Other ____ **Do you have family with diabetes?**
I don't know ____ Yes: ____ No: ____
Date of Diagnosis: _____ If yes, who? _____
Age at Diagnosis: _____ What type? _____
Management of Diabetes: How do you take care of your diabetes?
Diet/exercise: _____ Pills: _____ Insulin: _____ Other injection: _____

LABEL

Nutrition:

Do you have a current food plan/diet? Y ___ N ___ # of calories: _____

Type of plan: _____ Who does the cooking in your home? _____

How is the food prepared?

Baked ___ Boiled ___ Raw ___ Broiled ___ Fried ___ Other _____

Weight change in the past year? Y ___ N ___ If yes, Lost ___ lbs Gained ___ lbs;

In what period of time? _____ Reason? _____

What do you drink when you are thirsty? _____

How many times a week do you eat out? _____ Type of restaurant: _____

Meal Times: Breakfast: _____ Mid AM snack: _____

Lunch: _____ Mid PM snack: _____

Supper: _____ Bedtime snack: _____

Other meal/snack times: _____

What is your biggest challenges to healthy eating? _____

Exercise and Physical Activity:

Do you exercise? Y ___ N ___ Regularly? Y ___ N ___

If yes, what type(s)? _____

How many times a week? _____ How many minutes each time? _____

Do you exercise alone or with someone? _____

Do you have any problems with exercising or has your doctor or provider/nurse practitioner advised you to limit your activities/exercise in any way? Y ___ N ___

If yes, please explain: _____

Home Diabetes Testing:

Do you test your blood glucose (sugar)? Y ___ N ___ Name of the meter? _____

How often? _____ Time of tests: _____ Do you keep a record? Y ___ N ___

Average results _____

Do you have a target blood glucose range? _____

How do you dispose of used lancets (fingerstick needles)? _____

Do you ever have high blood glucose (high sugar)?

Yes: ___ No: ___ If yes, when/how do you take care of it? _____

Why does this happen? _____

Do you test your urine for ketones? Yes: ___ No: ___

If yes, did you have ketones? _____ or ketoacidosis? _____

If yes, how was it treated? _____

Do you ever have low blood glucose (low sugar)?

Yes: ___ No: ___ If yes, when/how do you take care of it? _____

Why does this happen? _____

Medicines for Diabetes (pills)

<u>Name</u>	<u>Dose</u>	<u>Time Taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medicines for Diabetes (insulin or other injection)

Name _____ Amount _____ When taken _____
 Name _____ Amount _____ When taken _____

Who prepares the injections and gives the medicine? _____

Where do you inject? _____

How do you store the medicine? _____

How do you take your medicine? Using vial and syringes ____ Pen ____ Pump ____

Reuse syringes Y ____ N ____ How do you dispose of syringes? _____

Medicine for other conditions, prescription, over the counter and supplements:

Attach separate page, if needed.

Name _____ Dosage _____ When taken _____

Name _____ Dosage _____ When taken _____

Name _____ Dosage _____ When taken _____

General Health: Food and Medication Allergies: _____

Do you have any of these health problems (check all that apply)? Please give details.

High blood pressure ____ If yes, what is your average BP? _____

Heart disease ____ If yes, explain: _____

High cholesterol ____ If yes, explain: _____

Thyroid disease ____ If yes, explain: _____

Kidney/bladder problems ____ If yes, explain: _____

Eye/vision problems ____ If yes, explain: _____

Foot problems ____ If yes, explain: _____

Numbness/pain ____ If yes, explain, including location: _____

Balance problems ____ If yes, explain: _____

Frequent Infections ____ If yes, what kind? _____

Sexual function problems ____ If yes, explain: _____

Other medical problems ____ If yes, explain: _____

Last flu shot: ____ Last pneumonia vaccine: ____ Last foot exam/Results _____

Last dilated eye exam/Results _____ Last dental exam/Results _____

Hospitalizations (in the past year or related to diabetes), including dates/reasons

Alcohol: Y ____ N ____ Drinks per week: _____

Tobacco: Y ____ N ____ Type: _____ # per day: _____ When started _____

Recreational Drugs: Y ____ N ____ Explain: _____

Do you wear medical ID? Y ____ N ____

How do you rate your health? Poor 1 2 3 4 5 6 7 8 9 10 Very Good

Diabetes Health Beliefs, Goals, Attitudes. Please answer each of the following:

I find it hard to believe that I really have diabetes Y ___ N ___

Paying for diabetes care is a problem Y ___ N ___

I have difficulty managing my diabetes Y ___ N ___

I feel unhappy because I have diabetes Y ___ N ___

All things considered I feel satisfied with my life Y ___ N ___

Does your culture influence or affect your decisions about diabetes (e.g. special or fasting or religious observances)? Y ___ N ___

If yes, explain: _____

Who is your support person(s)? _____

Please rate the level of stress/tension in your life (circle one) Low Moderate High

What causes your stress? _____

How do you cope with stress? _____

What are your strengths in dealing with health issues? _____

What questions do you have about diabetes? _____

What goals do you have for your education appointment(s)? _____

Participant Signature _____ **Date:** _____

Educator Signature _____ **Date:** _____

Date _____ Ht: _____ Wt: _____ BMI: _____ BP: _____ A1c: _____ BG: _____

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Lab data by history:

Fasting blood glucose _____ HbA1c _____ Urine microalbumin _____

Total Cholesterol _____ HDL _____ LDL _____ Triglycerides _____