University of South Florida Diabetes Center
Adult Diabetes Education Assessment Record

Have you signed up for the Diabetes Registry? ☐ Yes ☐ No If no, please go to www.usfdiabetescenter.org and sign up today.

Date: ______________
Name: ____________________________ Date of Birth: ______________ Age: _____
Address: __________________________ **Email address**: _______________________
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:
Discussion____
Reading ____
Lecture____
Video/TV/Computer____
Hands On ____

Problems with reading/learning? Y____ N____
If yes, what are they? ___________________
____
Barriers/Difficulties: Complete only what applies
Visual_____________________________________
Hearing____________________________________
Other______________________________________

Your Diabetes Is:
Type 1____
Type 2 ____
Gestational _____
Other ____
I don’t know _____
Date of Diagnosis: _________
Age at Diagnosis: _________

Were you taught to take care of diabetes?
Yes: ____ No: ____
If yes, when?______________________________
By whom? ________________________________
Do you have family with diabetes?
Yes: ____ No: ____
If yes, who? ______________________________
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?____

LABEL

Medicines for Diabetes (pills)

Name ______________ Dose ______________ Time Taken ______________

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

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 _____

LABEL

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/depressed 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 foods or fasting or religious observances)?
Y ___ N ___ If yes, how ____

Who do you consider your support person(s)? ______________________________
How do you rate the level of stress/tension in your life?
Low Moderate High Very High
What are your stressors? ____
____
How do you cope with stress? ____
____
What do you see as your individual strengths to help you deal with your diabetes?
____
Who will attend class? ____
Concerns, questions, goals: ____

____

Participant Signature _____________________________ **Date**: ____________
Educator Signature _______________________________ **Date**: ____________

Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______
Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______
Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______

Lab data by history:
Fasting blood glucose ________ HbA1c ________ Urine microalbumin ___________
Total Cholesterol ___________ HDL______ LDL_______ Triglycerides___________

LABEL