

**Personal Information**

Name \_\_\_\_\_ (first / last)      DOB \_\_\_\_\_ (month/day/year)      Age \_\_\_\_\_      Sex: M / F

Address \_\_\_\_\_ street, apt #      \_\_\_\_\_ city      \_\_\_\_\_ state      \_\_\_\_\_ zip

Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Work Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Cell Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Education Completed:     Grade School     High School     Some College     College Graduate

From whom do you get support for your diabetes?     Family     Co-Workers/Friends     Healthcare Providers     No One  
 Other \_\_\_\_\_

**Special needs:**

Visually Impaired     Deaf     Interpreter (language) \_\_\_\_\_     Other needs \_\_\_\_\_

Do you need help understanding written medical directions?     Yes     No

Do you have cultural, religious or health beliefs that influence how you take care of your diabetes? \_\_\_\_\_

**Medical History (check all that apply)**

My General Health is:     Excellent     Good     Fair     Poor

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Numbness/Tingling ( <input type="checkbox"/> Feet / <input type="checkbox"/> Hands) | <input type="checkbox"/> Vision Problems/Loss of Sight    | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Dry Skin/Other Skin Problems  | <input type="checkbox"/> Reflux/Digestion Problems        | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Slow Healing Wounds   | <input type="checkbox"/> Thyroid Problems                 | <input type="checkbox"/> Heart Problems      |
| <input type="checkbox"/> Kidney Problems/Urinary Tract Infections  | <input type="checkbox"/> Other Hormone/Endocrine Problems | <input type="checkbox"/> Other _____         |
| <input type="checkbox"/> Sexual Dysfunction  | <input type="checkbox"/> Diabetes Related to Pregnancy    | _____  |
| <input type="checkbox"/> Sleep Apnea/Snoring   | <input type="checkbox"/> Family Members with Diabetes     |  |

**Diabetes History**

Type of Diabetes:     Type 1     Type 2     Gestational     Pre-Diabetes     Don't know     Other \_\_\_\_\_

Year of Diagnosis \_\_\_\_\_ What concerns you most about your diabetes? \_\_\_\_\_

What is the most difficult part for you in caring for your diabetes? \_\_\_\_\_

Have you ever received diabetes education with a nurse or dietitian?     Yes     No

If yes, where/year \_\_\_\_\_

How do you learn best?     Listening     Reading     Observing     Doing

Are you ready to make changes for diabetes care?     Almost Ready     Ready     Already Working on Changes  
 Met Goals & Trying to Maintain

**My goals for this visit today are:** \_\_\_\_\_

**OVER →**

23.0003



**Olathe Medical Center**  
20333 West 151<sup>st</sup> Street  
Olathe, Kansas 66061

**OUTPATIENT DIABETES  
ASSESSMENT FORM**

Page 1 of 3

11.7.18; KT/EDU

**O.M.C. No. 1846**

PLACE  
PATIENT LABEL  
HERE

**PLEASE LIST ALL MEDICATIONS YOU TAKE ON A DAILY BASIS:**

\_\_\_\_\_  
\_\_\_\_\_

**Current Diabetes Treatment:**  None  Diet & Exercise  Oral Diabetes Medication  Injections

How much Insulin do you take: Before breakfast \_\_\_\_\_ Before Lunch \_\_\_\_\_

Before Supper \_\_\_\_\_ At Bedtime \_\_\_\_\_

Problems/Side Effects from medications? \_\_\_\_\_

Do you have **low blood sugars**?  Never  Infrequently  Weekly  Daily

Do you have any concerns about your ability to afford treatment? \_\_\_\_\_

**Blood Glucose Testing Frequency**

How often do you check blood sugar? \_\_\_\_\_

Name/Brand of Blood Glucose Meter \_\_\_\_\_ Year Obtained \_\_\_\_\_

Range of Blood Sugar \_\_\_\_\_

low high

**Physical Activity** Do you exercise regularly?  Yes  No If yes, type \_\_\_\_\_

Duration \_\_\_\_\_ Frequency \_\_\_\_\_ Intensity:  Light  Medium  Heavy  
(amount of time) (number days per week)

**Nutrition** Height \_\_\_\_\_ Weight \_\_\_\_\_ My weight goal is: \_\_\_\_\_  
feet inches

Do you currently follow a meal plan?  Yes  No If yes, what kind \_\_\_\_\_

**Risk Factors**

Do you smoke?  Yes  No If yes, how long? \_\_\_\_\_ years Packs per day \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, number of drinks per day \_\_\_\_\_ per week \_\_\_\_\_

**Time:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Patient signature:** \_\_\_\_\_

Diabetes Education Needs (office use only)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Disease Process & Treatment Options | <input type="checkbox"/> Medication Use           | <input type="checkbox"/> Healthy Coping   |
| <input type="checkbox"/> Nutritional Management              | <input type="checkbox"/> Monitoring Blood Glucose | <input type="checkbox"/> Problem Solving  |
| <input type="checkbox"/> Physical Activity                   | <input type="checkbox"/> Complications            | <input type="checkbox"/> All of the above |

**Time:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Reviewed by Diabetes Educator:** \_\_\_\_\_

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Page 2 of 3

11.7.18; KT/EDU

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**Living Will/Advance Directive**

Do you have a Living Will or Advance Directive for healthcare?  Yes  No  
(not applicable if less than 18 years of age)

If you answered no, would you like a written document of a Living Will/Advance Directive?  Yes  No

**Domestic Violence**

Have you ever been hit, kicked, punched, strangled or threatened?  Yes  No

If yes, when? \_\_\_\_\_

Do you feel unsafe at home, at risk for injury or neglect by persons in your household or those who help provide for your care?  Yes  No

If yes, when? \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_ Patient signature: \_\_\_\_\_

Time: \_\_\_\_\_ Date: \_\_\_\_\_ Reviewed by: \_\_\_\_\_

Action Taken:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Page 3 of 3

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