St. Francis Hospital
DIABETES TREATMENT–
EAST MEDICAL OFFICE BUILDING

2093 Henry Tecklenburg Drive, Ste. 201
Charleston, SC 29414
Phone (843) 402-1099 Fax (843) 402-1236

Initial Assessment

(Please complete front and back of this form)

Date: _____ **Visit type: Class**

Demographics:

Name: _____ Date of Birth: _____
Age: _____ Doctor: _____
Current occupation and work hours/shifts: _____
Who lives with you? _____Who is your main support person? _____
When you were diagnosed with diabetes? _____ Type of diabetes: □Type I □ Type II □Pre-diabetes

Meal Planning, Nutrition and Exercise:

Height: _____ Weight: _____ Recent weight loss/gain: _____
What has been your lowest body weight in the last ten years? _____
What do you consider to be a healthy weight for yourself? _____
Have you ever been given a meal plan, if so how many calories? _____
Do you currently have a meal plan for your diabetes? _____
Have you followed any meal plan program before? Is so, what program and when. _____
Current meal restrictions/religious limitations/allergies: _____
What is your biggest challenge when it comes to food? _____
Who does your grocery shopping/cooking? _____
How many times each week do you eat out? _____
Do you exercise? What type and how often? _____

Monitoring and Self-Care:

How often do you check blood sugars? Never 2-3 times/week 1 time each day 2-3 times/day
When do you check your blood sugar: _____
Do you have your own blood sugar machine? What kind? _____
What is your blood sugar range: _____ to _____
Blood sugar readings: Fasting _____ Other_____
Do you ever have blood sugar readings higher than 200? How often? _____
Do you ever have blood sugar readings lower than 70? How often? _____
Do you understand how to manage diabetes when you are sick? _____
Have you been admitted to the hospital because of diabetes? _____
If yes, when? _____

General Health:

Health conditions, other than diabetes, please circle:

High Blood Pressure	High Cholesterol	High Triglycerides	Obesity
Stroke	Heart Disease	Kidney Disease	Sleep Apnea
Arthritis	Thyroid Disease	Depression	Gastroparesis
Amputation	Eye Disease	Dental Disease	
Stomach or Bowel Problems	Osteoporosis	Allergies	
Frequent Infections	Other: _____		

Do you smoke? ____ How many packs per day? _____ For how long? _____
Have you ever tried to quit smoking? _____
Do you drink alcohol? _____ Type of alcohol, if so? _____ How often? _____

✓ *(please turn over to complete page 2)*

Do you have any of the following health problems caused by diabetes? If yes, please circle:

Numbness/tingling/loss of feeling in your feet	Kidney Problems
Eye Problems	Dental Problems
High Blood Pressure	High Cholesterol
Sexual Problems	Gastroparesis

Monitoring:

Do you check your feet daily? □ Yes □ No
Had a foot exam by a physician? □ Yes □ No If yes, date: _____
Have you had a dilated eye exam? □Yes □No If yes, date: _____
Received a flu shot and/or pneumonia vaccine in past 12 months? □ Yes □ No
How often do you go to the dentist? _____
Please provide most recent A1c% result and date. _____□N/A
Please provide most recent cholesterol result and date. _____ □N/A
Please provide most recent blood pressure result and date._____ □N/A

Medications:

List any allergies to medications: _____
Do you take diabetes medications? □ Yes □ No
Please check all that apply and list doses and how often you take the medication.
□ Diabetes Pills _____
□ Byetta/Bydureon/Victoza/Tanzeum/Symlin _____
Insulin shots _____
Inhaled insulin _____
If on insulin, method of administration: □ Pen □ Pump □Syringe

List **all** medications that you are currently taking.
List doses, how often, and when you take them.
(Including insulin, water pills, vitamins/herbal supplements)

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.
6.	14.
7.	15.
8.	16.

Learning needs/goals:

Have you ever seen a dietitian or diabetes educator? □ Yes □ No When? _____
What is the last grade completed in school? _____
Do you have any learning disabilities (dyslexia) or problems with vision, hearing, or reading? Please explain:
_____

Additional Information:

Does diabetes cause other problems for you? If yes, in which areas?
Finances Depression Insurance Relationships Problems at work
*Other*_____
What concerns you most about diabetes? _____
What is the hardest for you in caring for diabetes? _____
How do you handle things that worry you? _____

I am ready to make changes to my lifestyle for better blood sugar control.
1 2 3 4 5
Not----------Very

Diabetes Treatment Center Staff: *signature indicates completion of assessment*
Signature/title: _____ Date _____