

HILLCREST HEALTHCARE SYSTEM **TULSA, OKLAHOMA 74104**

ASSESSMENT DIABETES MANAGEMENT HMC3527 (Revised 06/15)

Patient Label

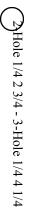
Name:								
					Work:			
May we leave a mess	sage at these numbers? [☐ Yes ☐ No						
May we contact you b	y e-mail? ☐ Yes ☐ No	If yes, email a	ddress:					
Occupation:				☐ Day S	Shift	☐ Night Shift		
Education Level:				☐ High School Degree☐ Post Graduate Degree				
How do you learn bes	t? (Check all that apply)	Listening	□ Wat	ching	□На	ands On/Doing		
Do you have any phys	sical limitations that affect \Box				ns	☐ Problems with mobility/movemen		
Do you have any cultu	ure factors that may affect	your diabetes care?	□Yes	□No				
If yes, please list:								
	osed or told you have prob							
Please check Yes	<u> </u>	,		Yes	No	1		
High Blood Pressur	e					_		
High Cholesterol								
Heart attack or Con	gestive Heart Failure							
Kidney or bladder p	roblems							
Numbness/pain/ting	gling in hands or feet							
Eye disease (retino	pathy, cataract, glaucoma))						
Depression								
Frequent nausea/vo	omiting/constipation/diarrh	ea						
Have you had diabete Healthy Coping	e you diagnosed with diabset seducation in the past?	□ Yes □ No		es, what ye	ear? _			
OVERWHELMED (OUT OF CONTROL BU	RDENED ALONE	E ANGR	Y AC	CEPTI	ING MOTIVATED		
Do you have a suppor	t person at home?	☐ Yes ☐ No						
Monitoring Do you use a meter to	o check your blood sugar?	□ Yes □ No	o If ye	s, what br	and is	s it?		
How often do you che	ck your blood sugar?	Occasionally 1	time/day [2 times/c	day	☐ 3 times/day ☐ 4 or ore times/d		
	record of your blood suga	nrs? ☐ Yes [□ No					
Do you keep a written								
	plood sugar goals with you	r physician? 🗌 Ye	es 🗆 No					



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Medication: Do you take pills for your diabete	es? □Yes □No		
Name of Pills	Dose	How many taken?	What time?
L Dut of the past 7 days, how mar	v davs have vou missed ta	l aking vour diabetes medications	s?
•		□4 □5 □6 □7	
Oo you take insulin?	∃Yes □ No		
Insulin Type	Units taken	What time is it taken?	Where do you inject?
ilisuliii Type	Offits taken	What time is it taken?	where do you inject?
Out of the past 7 days, how mar		□4 □5 □6 □7	
Do you have trouble paying for y	our medications or your do	octor's visits?	No
Physical activity:			
Oo you exercise regularly?	☐ Yes ☐ No		
f yes, how often? Once we	ekly 2-3 times/week	☐ 4 or more times/week	
Гуре of exercise: ☐ Walk ☐	Swim ☐ Bike ☐ Exerci	se class 🔲 Resistance training	g Other
For how many minutes each ses	sion?		
Risk Reduction: Over the past week, how many lo	ow blood sugar readings ha	ave you had?	□ 2 □ 3 □ 4+
Oo you wear a bracelet/keep sor	mething with you to identify	that you have diabetes?	☐ Yes ☐ No
Oo you carry a fast-acting sugar	source with you at all times	s? □ Yes □ No	
Oo you drink alcohol? ☐ Ye	- □Na If you how m	ony drinko?	k □ 1 per day □ 2 per day □ 3+ per
	s □ No If yes, how m		.k _ i per day _ z per day _ 5 · per
o you use tobacco? ☐ Yes	-		□2 □3 □4 □5+





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nave the following	ig things happened in the past year?			1		
			Yes	No		
Had an eye exan						
Had feet checke						
Saw a dentist						
Had a flu and/or	Had a flu and/or pneumonia vaccine					
Had blood press						
Had cholesterol	and triglycerides checked					
Had an A1C test						
Received help to						
Healthy Eating: Do you usually eat Please write down	ls?	☐ Yes ☐ No				
Meal/Snack	Type of food eaten		Where eaten			
Wical/Orlack	Type of food cateri					
BREAKFAST Time:						
Morning						
Snack:						
LUNCH Time:						
Afternoon						
Snack						
DINNER Time:						
Bedtime Snack						
Current Height:	Current Weight: Goal Weight:		_			
Signature:						