Staple

2Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

1113527

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

ASSESSMENT DIABETES MANAGEMENT
HMC3527 (Revised 06/15)

Personal and Health History:

Name: _____

Phone: Home: _____ Cell: _____ Work: _____

May we leave a message at these numbers? ☐ Yes ☐ No

May we contact you by e-mail? ☐ Yes ☐ No If yes, email address:_____

Occupation: _____ ☐ Day Shift ☐ Night Shift

Education Level: ☐ Elementary School ☐ Some High School ☐ High School Degree
☐ Some College ☐ College Degree ☐ Post Graduate Degree

How do you learn best? (Check all that apply) ☐ Listening ☐ Watching ☐ Hands On/Doing

Do you have any physical limitations that affect your ability to perform your self-care?
☐ Hearing problems ☐ Vision problems ☐ Problems with mobility/movement

Do you have any culture factors that may affect your diabetes care? ☐ Yes ☐ No

If yes, please list:_____
Label

Have you been diagnosed or told you have problems with any of the following?

Please check Yes or No	Yes	No
High Blood Pressure		
High Cholesterol		
Heart attack or Congestive Heart Failure		
Kidney or bladder problems		
Numbness/pain/tingling in hands or feet		
Eye disease (retinopathy, cataract, glaucoma)		
Depression		
Frequent nausea/vomiting/constipation/diarrhea		

During what year were you diagnosed with diabetes? _____

Have you had diabetes education in the past? ☐ Yes ☐ No If yes, what year? _____

Healthy Coping

Circle the words that describe how you feel about your diabetes?

OVERWHELMED OUT OF CONTROL BURDENED ALONE ANGRY ACCEPTING MOTIVATED

Do you have a support person at home? ☐ Yes ☐ No

Monitoring

Do you use a meter to check your blood sugar? ☐ Yes ☐ No If yes, what brand is it? _____

How often do you check your blood sugar? ☐ Occasionally ☐ 1 time/day ☐ 2 times/day ☐ 3 times/day ☐ 4 or ore times/day

Do you keep a written record of your blood sugars? ☐ Yes ☐ No

Did you discuss your blood sugar goals with your physician? ☐ Yes ☐ No

Patient Label

1113527

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

ASSESSMENT DIABETES MANAGEMENT
HMC3527 (Revised 06/15)

Staple

2 Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Medication:

Do you take pills for your diabetes? ☐ Yes ☐ No

Name of Pills	Dose	How many taken?	What time?

Out of the past 7 days, how many days have you missed taking your diabetes medications?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you take insulin? ☐ Yes ☐ No

Insulin Type	Units taken	What time is it taken?	Where do you inject?

Out of the past 7 days, how many days have you missed taking your insulin dose(s)?

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you have trouble paying for your medications or your doctor's visits? ☐ Yes ☐ No

Physical activity:

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often? ☐ Once weekly ☐ 2-3 times/week ☐ 4 or more times/week

Type of exercise: ☐ Walk ☐ Swim ☐ Bike ☐ Exercise class ☐ Resistance training ☐ Other_____

For how many minutes each session? _____

Risk Reduction:

Over the past week, how many low blood sugar readings have you had? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Do you wear a bracelet/keep something with you to identify that you have diabetes? ☐ Yes ☐ No

Do you carry a fast-acting sugar source with you at all times? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks? ☐ 1-2 per week ☐ 1 per day ☐ 2 per day ☐ 3+ per day

Do you use tobacco? ☐ Yes ☐ No If yes, how many times per day? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+

If yes, check all that apply: ☐ Cigarettes ☐ Cigars ☐ Smokeless ☐ E-cigarettes

Patient Label

Staple

1113527

HILLCREST HEALTHCARE SYSTEM
TULSA, OKLAHOMA 74104

ASSESSMENT DIABETES MANAGEMENT
HMC3527 (Revised 06/15)

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

Have the following things happened in the past year?

	Yes	No
Had an eye exam		
Had feet checked by a healthcare provider		
Saw a dentist		
Had a flu and/or pneumonia vaccine		
Had blood pressure checked		
Had cholesterol and triglycerides checked		
Had an A1C test		
Received help to stop smoking (only for people who smoke)		

Healthy Eating:

Do you usually eat 3 meals per day? ☐ Yes ☐ No Do you ever skip meals? ☐ Yes ☐ No

Please write down what you eat in a typical day?

Meal/Snack	Type of food eaten	Where eaten
BREAKFAST Time:		
Morning Snack:		
LUNCH Time:		
Afternoon Snack		
DINNER Time:		
Bedtime Snack		

Current Height:_____ Current Weight:_____ Goal Weight:_____

Signature:_____

Patient Label