Diabetes

RESET FORM

UnityPoint Health
Des Moines

Name: _____ Preferred Name: _____ DOB: _____ Date: _____

LIFESTYLE/COPING

Status: ☐Single ☐Married Who lives with you: _____

Do you work? ☐Yes ☐No Type of work and work hours: _____

Last grade completed: ___ Can you read/write English? ☐Yes ☐No Primary Language: _____ Race: _____

Cultural or religious beliefs that may impact care: _____

How do you learn best? ☐Listening ☐Doing ☐Discussing ☐Reading ☐Pictures/Videos ☐Other: _____

Tobacco Use: ☐Yes ☐No Type/Amount? Quit Date: _____

Alcohol Use: ☐Yes ☐No Type/Amount? Quit Date: _____

Chronic Pain: ☐Yes ☐No How often does it affect your lifestyle: _____

DIABETES DISTRESS SUPPORT

In the past month, distressed or bothered by feeling overwhelmed by demands of living with diabetes? ☐Yes ☐No

In the past month, distressed or bothered by feeling your failing with diabetes routine? ☐Yes ☐No

BEING ACTIVE/PHYSICAL ACTIVITY

Exercise Frequency/week: _____ Exercise Duration: _____

Type of Exercise: _____

CLINICAL HISTORY

YES	NO		YES	NO	
		Eye Problems:			Have you felt little interest or pleasure in doing things over the past 2 weeks?
		Nerve Problems			Have you felt down or depressed over the past 2 weeks?
		Kidney Problems			
		Stomach or Bowel Problems			Are you pregnant? If so, when are you due:
		Foot Problems			Are you planning to get pregnant?
		Sexual Function Problems			
		Frequent Infections			**ACUTE COMPLICATIONS: Preventing/Detecting/ Treatment** How do you manage your diabetes when you are sick?
		Heart Problems			
		Lung Breathing Problems			
		High/Low Blood Pressure			
		Stroke - when notes:			Do you wear a medical ID?
		Arthritis notes			Hyperglycemia (350 or more)? How often:
CHRONIC COMPLICATIONS: Preventing/Detecting/Treatment					How do you treat hyperglycemia?
		Do you have a primary care doctor?			Have you ever had DKA? When?
		Date of last professional foot exam:			Do you ever test for ketones? What would you do if you had ketones?
		Do you exam your feet daily?			Do you have hypoglycemia? How often?
		Date of last dilated eye exam:			Can you tell when you have hypoglycemia?
		Date of last dental exam:			

Patient Label

DIABETES INITIAL ASSESSMENT QUESTIONNAIRE

How are you prepared with diabetes medications and supplies in case you had to leave your home with little notice and uncertainty of how long? _____

MONITORING GLUCOSE AND HEALTH LITERACY

When do you check your blood glucose? _____

Blood Glucose Meter/CGM type: _____

What are your blood glucose readings? _____

What are you Blood glucose targets? _____

If using CGM what is your TIR target? _____

What is your A1C GOAL? _____

What are your goals for the education session? _____

TAKING MEDICATIONS AND HEALTHY LITERACY

DM oral medications:

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Insulin/DM injectable meds:

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

Name: _____ Dose: _____ CAN IT CAUSE LOW BGS: ☐Yes ☐No

CORRECTION SCALE: ☐Yes ☐No Correction Scale _____ units for every _____mg/dl above _____mg/dl

Injection sites: _____ Rotate Sites ☐Yes ☐No

How do you store your medications? _____

_____

Educator Completes This Section:

DIABETES PATHOLOGY AND TREATMENT

Diabetes type: _____ When diagnosed: _____

Height: _____ Weight: _____ Last A1C: _____ Date: _____

Labs: Date: _____ Chol: _____ HDL: _____ LDL: _____ Triglycerides: _____

EGFR: _____ Date: _____ See EMR for above values

Previous Diabetes Education: ☐Yes ☐No If previous diabetes education, when/where: _____

HEALTH EATING HEALTH LITERACY

Do you follow a meal plan: ☐Yes ☐No Know which foods raise BG: ☐Yes ☐No

Able to read food labels: ☐Yes ☐No Meals eaten: ☐Breakfast ☐Lunch ☐Supper

Food Beverage Snack Notes: _____

_____

Food allergies/GI issues: _____ Who shops/cooks? _____

EDUCATION PLAN

Needs referral to Dietician for Medical Nutrition Therapy ☐Yes ☐No

Education Plan developed with patient to include: ☐Diabetes Pathophysiology ☐Healthy Eating

☐Being Active: ☐Taking Medications ☐Monitoring Glucose ☐Acute Complications

☐Chronic Complications ☐Lifestyle and healthy coping ☐Diabetes distress and support

☐ Group DSMT: ☐ Individual DSMT; ☐ Group MNT; ☐ Individual MNT; ☐Follow up Group: ☐Follow up individual

Permanent Part of the Medical Record

Patient Label

DIABETES INITIAL ASSESSMENT QUESTIONNAIRE