LifeHelp Nutrition and Diabetes Center
Patient Assessment Form

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Home Phone: _____ Other Phone: _____ Insurance Carrier: _____

Have you ever received diabetes education before? No ☐ Yes ☐ When? _____ Where? _____

Health History

When were you diagnosed with diabetes? _____ What type do you have? 1 ☐ 2 ☐ I don't know ☐

Please list any medical conditions: _____

When was your last eye exam?_____ Last foot exam?_____

Do you smoke? Yes ☐ (Packs Per Day_____) Never ☐ Quit ☐ (When?)_____

Social History

Does anyone provide you with practical or emotional support for your diabetes? Yes ☐ No ☐

Do you have any possible barriers to learning? Yes ☐ No ☐

Hearing: ☐ Visual: ☐ Language: ☐ Education: ☐ Other (specify) _____

Do you have financial concerns that affect your health care? Yes ☐ No ☐

Do you have any cultural or religious customs that may affect your diabetes care? Yes ☐ No ☐

High and Low Blood Sugar

Have you had any episodes of hyperglycemia (blood sugar > 350)? Yes ☐ No ☐

Have you had any episodes of low blood sugar (blood sugar < 70)? Yes ☐ No ☐

Do you have warning signs of low blood sugar? Yes ☐ No ☐

Do you wear a medical ID that states you have diabetes? Yes ☐ No ☐

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St. Anthony's Hospital
BayCare Health System

LifeHelp

StAnthonys.org/LifeHelp

Blood Sugar Testing

Do you test your blood glucose at home? Yes ☐ No ☐ How often? _____

What type of meter do you use? _____

Do you have problems testing your glucose? _____

Nutrition History

Height: _____ Weight: _____

Please describe any recent change in your weight: _____

Are you following any meal plan at this time? Yes ☐ (explain) _____ No ☐

Who is responsible for most of the food shopping? _____

Who is responsible for most of the cooking? _____

How often do you eat out? _____

Do you drink alcohol? Yes ☐ No ☐

Type/Frequency: Beer ☐ Wine ☐ Liquor ☐ Rarely ☐ 1-3/ wk ☐ 1-2/ day ☐ 3+/ day ☐

Exercise Habits

Do you exercise? Yes ☐ No ☐

What type(s)? Walking ☐ Bicycling ☐ Swimming ☐

Other: _____

How many times per week do you exercise? 1-2 ☐ 3-4 ☐ 5-6 ☐ More than 6 ☐

Do you have hypoglycemia (low blood sugar) during or following exercise? Yes ☐ No ☐

Do you have any conditions that prevent you from exercising? _____

Do you have any chest discomfort when exercising? Yes ☐ No ☐

Behavior Change

What areas of diabetes management would you like to work on first? Nutrition ☐ Exercise ☐

Monitoring ☐ Medications ☐ Coping with it ☐ Preventing complications ☐ Other _____

What do you think you can do to help control your diabetes? _____

_____

Patient Signature: _____ Date: _____

Reviewed with patient by: _____ Date: _____