Hunterdon Health

Center for Nutrition & Diabetes Management

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Diabetes & Nutrition Assessment

PLEASE USE PEN. DO NOT USE PENCIL.

Name: ____________________ **Date of Birth:** __________________ **Date:** ________________________

Primary Care Physician ______________________ **Endocrinologist:** _____________________

What type of diabetes do you have? ☐ **Type 1** ☐ **Type 2**

Diabetes Education History:

Have you ever had diabetes education? ☐ Yes ☐ No When?___________________

Have you ever had nutrition education? ☐ Yes ☐ No When?___________________

If yes to question 1 or 2, enrollment date of **Medicare Part A** ____________ **Part B** ____________

The most important things I want to learn/concerns I have:__________________________

____

☐ Manage my blood sugar complications ☐ Manage my weight ☐ Plan meals ☐ Avoid

☐ Use a blood sugar meter ☐ Eat/follow healthy diet ☐ Portion control ☐ Read food labels

☐ Self-administer insulin ☐ Take better care of myself ☐ How to be consistent with exercise

☐ Insulin pumps ☐ Continuous Glucose monitoring (CGM)

Paying for: ☐ Supplies ☐ Medications ☐ Medical care ☐ Other: ________________________

Health problems/Surgeries: ____

____

History:

Stress- Your level on a scale of 1 to 10: (10 = very high):______________________

Family history of diabetes: ☐ Yes ☐ No

Living and Working Situation:

With whom do you live? ☐ Alone ☐ Spouse ☐ Family ☐ Friend ☐ Significant other. Do you have support in your diabetes management? If yes, who: _________________________

Are you employed? If yes, type of job: ______________________________________

Are you retired ☐ Yes ☐ No

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Exercise routine: ☐ Easy ☐ moderately intense ☐ very intense

What kind of exercise do you do?______________________________

Where do you exercise? ______________________________

How often:____ For how long?______________

Sleep Problems:

Do you have any sleep apnea? ☐ Yes ☐ No Do you use a CPAP machine? ☐ Yes ☐ No

Learning Needs:

Do you have any problems with hearing, vision or speech? ☐ Yes ☐ No Explain: ______________

Do you use diabetes, nutrition or physical activity apps? ☐ Yes ☐ No

What apps do you use?____

Feelings and Concerns:

How do you feel about having diabetes? ☐ Okay ☐ Anxious ☐ Angry ☐ Afraid ☐ Sad ☐ Alone

☐ Depressed ☐ Overwhelmed ☐ Burned out ☐ Unsure of what to do Other: ____________________

Depression:

Have you recently felt down, depressed, hopeless or have little or no interest/pleasure in doing things?

☐ Yes ☐ No

Are you being treated for depression? ☐ Yes ☐ No

Pain Assessment:

Do you have a condition that causes chronic pain? ☐ Yes ☐ No

Women's Health:

Have you had gestational diabetes? ☐ Yes ☐ No

Are you of childbearing age? ☐ Yes ☐ No. If yes, do you use contraception? ________________

Alcohol/Nicotine:

Do you drink alcohol? ☐ Yes ☐ No How much? ______ How often? ______ What do you drink?

☐ *Light Beer* ☐ Beer ☐ Wine ☐ Liquor

Do you use any nicotine products? ☐ Yes ☐ No If yes, ☐ Smoke cigarette ☐ Chew tobacco

☐ Cigars ☐ Pipe ☐ E-Cigarettes How much do you smoke? ______________________________

Diabetes History:

When were you diagnosed? ____________________

What are your symptoms of high blood sugar? ☐ None ☐ Hunger ☐ Thirst ☐ Ketoacidosis

☐ Frequent urination ☐ Dry skin ☐ Blurred vision ☐ Tired ☐ Frequent infections

☐ Erectile dysfunction ☐ Numbness/tingling in hands and feet ☐ Weight loss

Are there any cultural factors that affect your diabetes? ☐ Yes ☐ No

Explain: ____________________

Have you had any hospitalizations or emergency room visits because of your diabetes? ☐ Yes ☐ No

If yes, describe ____________________

Last dilated eye exam: __________ **Last dental exam:** __________ **Last foot exam:** __________

Self-Monitoring Skills:

Do you check your blood sugar? ☐ Yes ☐ No

When do you test? ☐ Fasting ☐ Before meals ☐ After meals ☐ Bedtime ☐ Before driving

What kind of meter do you use? __________ What are your blood sugar readings?

Do you use a continuous glucose monitoring system (CGM)? ☐ Yes ☐ No

What type: ☐ Dexcom CGM ☐ Libre personal ☐ Medtronic sensor with pump

Insulin Use:

Do you take insulin? ☐ Yes ☐ No If yes: ☐Pen ☐ Syringe ☐ Insulin Pump

Where do you inject? ☐ Arm ☐ Abdomen ☐ Thigh ☐ Other: ____________________

Do you skip or adjust your insulin? ☐ Yes ☐ No. If yes, please explain ____________________

____

Low Blood Sugar:

Have you ever had a low blood sugar? ☐ Yes ☐ No If yes, how frequently ____________________

What are your signs/symptoms of low blood sugar? ☐ Hunger ☐ Shakiness ☐ Sweating

☐ Anxiety ☐ Fast heartbeat ☐ Dizziness ☐ Weakness ☐ Irritability ☐ Vision change

☐ Headache ☐ Other ____________________

Why do you get low blood sugars? ☐ Too much insulin or oral medication ☐ Unexplained

☐ Skipped a meal/snack ☐ Increased exercise

What did you do to treat the low blood sugar? ☐ Nothing ☐ Called my doctor

☐ Ate lots of food ☐ Ate/drank food with fast acting sugar ☐ Went to the Emergency Room

☐ Do you wear diabetes identification? ☐ Yes ☐ No What kind? ____________________

High Blood Sugar:

Can you tell if you blood sugar is too high? ☐ Yes ☐ No

What do you do when blood sugar is high? ____________________

Nutrition:

1. Do you have any problems with?

   ☐ Gums ☐ Problems chewing ☐ Dentures

2. Do you have a meal plan for diabetes? ☐ Yes ☐ No

   If yes, how often do you use this meal plan? ☐ Never ☐ Sometimes ☐ Most of the time ☐ Always

3. Who prepares your meals for you?
4. How many times a week do you eat away from home?

   ☐ Fast food ☐ Restaurant ☐ Take out ☐ Other ________________________

5. Do you: ☐ Skip meals ☐ Nibble between meals ☐ Eat rapidly ☐ Have food cravings

   ☐ Use convenience food ☐ Eat unplanned meals ☐ Other ______________________

6. What are your main beverages? ____________________________
7. For each statement below please circle whether these statements were: often true, sometimes true or never true for your household in the last 12 months.

   We worried whether our food would run out before we got money to buy more.

   Often Sometimes Never

   The food we bought just didn't last and we didn't have money to get more.

   Often Sometimes Never

Is there anything else you would like the diabetes educator and registered dietitian to know?

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____

____

Patient Signature: _________________________________ Date: _____________________________

Diabetes Educator signature: ________________________ Date: _____________________________

Nutritionist Signature: ______________________________ Date: _____________________________

***** Continue to next page for Nutrition Food Log*****

Name: ____

Height: __________ Weight: __________ Recent Gain or Loss: ________________

Please record your food intake. What kind of food? How much food?

BREAKFAST Time__________	MORNING SNACK Time__________
LUNCH Time__________	AFTERNOON SNACK Time__________
DINNER Time__________	EVENING SNACK Time__________

____, RD Date: ______________