Hunterdon Health
Center for Nutrition & Diabetes Management
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Assessment For Insulin Users

PLEASE USE PEN. DO NOT USE PENCIL.

Name:_____ Date: _____

Primary Care Physician:_____Endocrinologist:_____

☐ Type 1 ☐ Type 2 Age at Diagnosis: _____

years with Diabetes: _____

Please describe any diabetes and nutritional education you have received since your diagnosis of diabetes and where it occurred.

_____

_____

Insulin Use:

Please indicate the insulin you use: _____

Long acting: _____

Rapid acting: _____

What is your Insulin Carb Ratio? _____

What is your Insulin Sensitivity Factor? (also called Correction factor)

_____

Oral Medications:

Please list any oral medications or non-insulin injectable medications that you take for diabetes: _____

_____

_____

Continuous Glucose Monitoring (CGM)/ Glucose Monitoring:

Do you wear or have you ever worn a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No
If yes, which one? : _____
If you do not wear a CGM how many times a day do you check your blood sugar? _____
Which meter do you use?_____

Nutrition:

Do you count carbohydrates? ☐ Yes ☐ No

How would you rate your carb counting ability? ☐ Good ☐ Fair ☐ Poor

Do you eat a high fat diet? ☐ Yes ☐ No ☐ Not Sure

Do you use apps to look up nutritional information? ☐ Yes ☐ No

If yes, which apps do you use? _____

What do you drink with your meals? _____

Do you skip meals? ☐ Yes ☐ No If yes, which meals? _____

How many times a week do you eat away from home? _____

_____Fast Food _____Restaurant _____Take Out Other_____

Exercise:

Do you Exercise? ☐ Yes ☐ No

What do you do for exercise? _____

How often do you exercise? _____

Do you adjust insulin dose for exercise? ☐ Yes ☐ No

What insulin adjustments do you make? _____

High Blood Sugar:

What do you do when your blood sugar is high? _____

Do you know what OKA is? ☐ Yes ☐ No

Have you had any episodes of OKA within the last two years? ☐ Yes ☐ No

Low Blood Sugar:

Do you carry a source of sugar with you at all times? ☐ Yes ☐ No

If yes, what do you carry?_____

Do you get symptoms with low blood sugar? ☐ Yes ☐ No

Do you have a prescription for Glucagon? ☐ Yes ☐ No

Have you ever needed assistance from another person to treat low blood sugar? (Glucagon, call to 911, or assistance getting food/drink) ☐ Yes ☐ No

If yes, please describe _____

Living and Working Situation:

With whom do you live? ☐ Alone ☐ Spouse ☐ Family ☐ Friend ☐ Significant other

Do you have support in your diabetes management? ☐ Yes ☐ No If yes, who:_____

Are you employed? ☐ Yes ☐ No If yes, type of job: _____

Are you retired? ☐ Yes ☐ No

Stress Level on a scale of 1-10 (10 = very high) _____

Sleep Problems: ☐ Yes ☐ No If yes, please describe:_____

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 interest 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:

Are you of childbearing age? ☐ Yes ☐ No. If yes, do you use birth control? ☐ Yes ☐ No
Method: _____

Have you had gestational diabetes? ☐ Yes ☐ No

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 cigarettes ☐ Chew tobacco ☐ Cigars ☐ Pipe ☐ E-Cigarettes How much do you smoke? _____

General Diabetes Information:

Are there any cultural factors that affect your diabetes? ☐ Yes ☐ No If yes, please explain
_____

Have you had any hospitalizations or emergency room visits because of your diabetes within the last two years? _____

☐ Yes ☐ No If yes, describe_____

Last Dilated eye exam: _____Last Dental Exam_____Last Foot Exam ____

Food Security:

I was worried 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

Anything else you would like us to know?_____

_____

_____

Patient Signature: _____ Date: _____

Diabetes Educator Signature: _____Date:_____

Registered Dietitian Signature: _____Date:_____

Name:_____

Usual Weight: _____ Goal Weight: _____Recent Gain or Loss: _____

Please record a "usual" day.
What kind of food? How much food?

BREAKFAST Time_____	MORNING SNACK Time_____
LUNCH Time_____	AFTERNOON SNACK Time_____
DINNER Time_____	EVENING SNACK Time_____