Hunterdon Health
Center for Nutrition & Diabetes Management
Wescott Medical Arts Building
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Phone: 908-237-6920 | www.hunterdonhealth.org

Pre-Diabetes Self-Assessment

Please fill out all of the information on this form and bring it to your nutrition appointment.

(Please use a pen. Do not use pencil.)

Name:_____Today's Date:_____

Referring Physician:_____ Primary Care Physician: _____

Height: _____Current Weight: _____Usual Body Weight:_____ Highest Weight: _____

Lowest Weight:_____

Medications - List all **medications, vitamins, herbs and supplements** you are taking:

Name	Dose	When Taken	Taking it as prescribed? Yes/No

Medicine/Food Allergies: _____

_____

Medical History: (please circle those that apply)

Diabetes High Cholesterol High Blood Pressure Heart Disease CHF Sleep Apnea

Arthritis Crohn's Disease Celiac Disease Cancer Eating Disorder Obesity

Polycystic Ovarian Syndrome (PCOS) Other: _____

Do you experience: ☐ morning headaches ☐ snoring ☐ periods of not breathing when sleeping ☐ awakening not rested in the morning ☐ Other:_____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Type of exercise: _____

How often do you exercise?_____ How long do you exercise? _____

Any exercise limitations? _____

Have you ever had an exercise stress test? _____If so, when?_____

Learning Style:

Learning Preference: ☐ Reading ☐ Discussion ☐ Internet ☐ DVD/CD ☐ Hands on training

Do you use a Smart Phone/Tablet? ☐ Yes ☐ No

If yes, have you used a nutrition or physical activity apps? ☐ Yes ☐ No
Which apps do you use?_____

Have you had previous diabetes or nutrition education? ☐ Yes ☐ No
If yes, where? _____and how long ago?_____

Do you have any problems learning about medical conditions because of difficulty understanding written information? ☐ Yes ☐ No

Are you confident in filling out medical forms independently? ☐ Yes ☐ No

How often do you have someone help you read hospital materials? ☐ Often ☐ Never

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Intake History:

The most important things we want to learn today are:

1. _____
2. _____
3. _____

Do you drink alcohol? ☐ Yes ☐ No If so, how much? _____

Do you smoke? ☐ Yes ☐ No If so, how much? _____

Do you have any religious or cultural observations that affect how you eat?

☐ Yes ☐ No If yes, please explain _____

Do you feel deprived regarding food and meals? ☐ Yes ☐ No

Do you feel uncomfortable in social situations related to food? ☐ Yes ☐ No

Do you constantly feel concerned about food and eating? ☐ Yes ☐ No
If yes, please explain _____
_____

Who prepares your meals?_____

How are your meals usually prepared? ☐ Fried ☐ Baked ☐ Grilled ☐ Broiled ☐ Other _____

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

☐ Fast Food ☐ Restaurant ☐ Take Out ☐ Other_____

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

☐ Use convenience foods ☐ Eat unplanned meals ☐ Other_____

How much milk or yogurt do you consume in one day? _____How many vegetables?_____

How many fruits? _____How much water do you drink in one day _____

What are your main beverages and how much? _____

Name:_____Date: _____

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: _____

Notes/Comments: _____

_____

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