Iowa Specialty Hospitals & Clinics
Specializing in You

Diabetes Education Patient Intake Form

Name: _____ Date of Birth: _____

Name you prefer to be called: _____ Todays Date: _____

Lifestyle/Coping Questions:

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who else lives in household? _____

Do you work? ☐ Yes ☐ No

Type of work: _____ Work hours: _____

Race: _____ Primary Language: _____

Please list cultural/religious beliefs that may impact your care: _____

Do you ever fast? ☐ No ☐ Yes: Explain _____

Last grade completed: _____ Can you read English? ☐ Yes ☐ No Can you write English? ☐ Yes ☐ No

Do you have any barriers to receiving care? ☐ Housing ☐ Utilities ☐ Food ☐ Transportation ☐ ADLs
☐ Caregiver ☐ Support Network ☐ None of the above ☐ Other _____

Do you have any difficulty with: ☐ Physical difficulty ☐ Seeing ☐ Hearing ☐ Reading ☐ Writing
☐ English as a second language ☐ None of the above ☐ Other _____

How do you prefer to learn? ☐ Written materials ☐ Verbal Discussion ☐ Videos ☐ Other _____

Tobacco Use ☐ No, never ☐ Previously, total years _____ Quit date _____
☐ Yes: Type _____ Amount _____
Interest in quitting? ☐ Yes ☐ No

Alcohol Use ☐ No ☐ Yes: Type _____ Amount _____

Recreational Drug Use ☐ No ☐ Yes: Type _____ Amount _____

Do you experience pain that affects your lifestyle? ☐ No ☐ Yes: Explain _____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Diabetes and Support Questions:

I have just been diagnosed with diabetes ☐ Yes ☐ No: Age/Year _____

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Prediabetes
☐ LADA ☐ MODY ☐ Do not know

I have attended diabetes classes in the past: ☐ Yes ☐ No

☐ Initial Education: Where: _____ When: _____

☐ Other Education: Where: _____ When: _____

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Have you had a hospital admission due to diabetes in the past 12 months? ☐ Yes ☐ No

If yes: Number of hospital admissions due to diabetes in the past 12 month: _____

Total number of days due to diabetes in the last year: _____

Visited primary doctor or endo or diabetes educator within 7-14 days after discharge: ☐ Yes ☐ No

Reason for hospital admissions due to diabetes: _____

Who else in your family has diabetes? ☐ Mother ☐ Father ☐ Sibling(s): _____

☐ Maternal Grandparent ☐ Paternal Grandparent ☐ Other _____

Have you been diagnosed with depression? ☐ Yes ☐ No

Have you had little interest or pleasure in doing things:

☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)

Experiencing feeling down, depressed or hopeless:

☐ Not at all (0) ☐ Several Days (1) ☐ More than Half the Days (2) ☐ Nearly Every Day (3)

What about your diabetes causes you stress or distress? _____

How do you deal with your stress or distress? _____

Who is your primary support person? _____ Relationship to you _____

How do you manage your diabetes when you are sick? _____

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? _____

Blood Glucose Testing:

☐ I do *not* have a blood sugar monitor (glucometer) ☐ I use a CGM (continuous glucose monitor)

☐ I do have a blood sugar monitor (glucometer) Name of glucometer/CGM _____

When do you test your blood sugars?

☐ Before breakfast after waking up; Ranges _____

☐ Before meals; _____ minutes before meals; Ranges _____

☐ After meals; _____ hours after meals; Ranges _____

☐ Before bedtime; Ranges _____

☐ Other; Explain _____

What are your blood sugar goal ranges / goal time in range? _____

Do you know what A1C lab means? ☐ No ☐ Yes: _____

What was your last A1C? _____ Date: _____ What is your A1c goal? _____

Do you know what your cholesterol, HDL, LDL, triglycerides, and eGFR labs mean? ☐ No ☐ Yes

When was your last full lab draw? _____

Diabetes Treatment:

Are you aware which of your medications can cause low blood sugar? ☐ No ☐ Yes: _____

Diabetes Medication(s): ☐ No Diabetes Medications

☐ Pill(s): Please list, including name, dosage, frequency _____

_____

☐ Non-Insulin Injectables(s): Please list, including name, dosage, frequency _____

_____

☐ Insulin(s): ☐ insulin vial/syringe ☐ insulin pen ☐ insulin pump

If you are using insulin, please list:			*If you are using Insulin Pump:*	
Name/Type of Insulin	# of Units	Time Taken	Insulin to Carb Ratio	
			Correction Factor (Insulin Sensitivity)	
			Target Blood Sugar	
			Make/Model of Pump	

Have a sliding scale? ☐ No ☐ Yes: Explain _____

The insulin device I use is: ☐ 3/10cc syringe ☐ 1/2cc syringe ☐ 1cc syringe ☐ Insulin pen

The insulin needle length is: ☐ 12mm (original) ☐ 8mm(short) ☐ 5mm (mini) ☐ 4mm (nano)

My insulin injection sites are: ☐ stomach ☐ buttocks/hips ☐ thighs ☐ arms ☐ other _____

I keep the insulin I am using: ☐ refrigerated ☐ unrefrigerated

I keep spare bottles of insulin: ☐ refrigerated ☐ unrefrigerated

I put used syringes in: ☐ sharps container ☐ the trash ☐ milk jug, coffee can, or other container

I reuse my syringes/needles: ☐ Yes ☐ No

I use alcohol to clean my skin and wipe the insulin bottle/pen: ☐ Yes ☐ No

Sometimes I change my insulin dose on my own. ☐ Yes ☐ No

I have taken a class about adjusting insulin safely. ☐ Yes ☐ No

Nutrition Information

Have you had any changes in appetite? ☐ No ☐ Yes: Explain _____

Have you had any recent weight loss? ☐ No ☐ Yes: Explain _____

Have you had any recent weight gain? ☐ No ☐ Yes: Explain _____

Current Height: _____ Current Weight: _____ Goal Weight: _____

Who shops for food at home? ☐ Self ☐ Other: _____

Who prepares meals at home? ☐ Self ☐ Other: _____

What types of food do you like to enjoy for

Breakfast _____

Lunch _____

Supper _____

Snacks _____

Home meal plan: ☐ I don't follow a specific plan ☐ I count carbohydrate choices ☐ I count grams of carbs

☐ Plate method ☐ Other _____

How frequently do you eat out? ☐ 1-2 times/month ☐ 1-2 times/week ☐ 3-4 times/week ☐ Daily

Favorite restaurants/fast food places _____

Food allergies/restrictions/GI issues _____

Are you aware of what foods can raise your blood sugar? ☐ No ☐ Yes: _____

Are you confident in reading a nutrition facts label? ☐ No ☐ Yes ☐ Would like a review

What is your biggest challenge to eating healthy? _____

How confident are you in making healthy choices? ☐ Not at all ☐ Somewhat ☐ Confident ☐ Very

In the past 12 months, were there times when it was difficult to buy enough groceries? ☐ Yes ☐ No

Do you use any of the following food assistance programs:

☐ WIC ☐ Food Stamps ☐ Meals on Wheels ☐ Food Pantry ☐ Community Meals

Would you like more information about these programs? ☐ Yes ☐ No

Being Active

What physical activity do you do regularly? _____

How often? _____

What, if any, barriers do you have to physical activity? _____

Do you sometimes get pain in your calves and have to stop? ☐ Yes ☐ No

Do you sometimes get chest pain or heaviness and have to stop? ☐ Yes ☐ No

Today's Appointment

What questions do you have today? What would you like to learn about regarding your health?

☐ About diabetes and treatment options ☐ Complications of Diabetes ☐ Lab interpretation/goals

☐ Healthy eating ☐ Being Active ☐ Medications ☐ Monitoring glucose ☐ Lifestyle and healthy coping

☐ Distress and support resources ☐ Other _____

What are your goals for today's appointment? _____

What are two things you need help with to improve your diabetes?

1) _____ 2) _____

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Is there anything else you would like your diabetes educator to know? _____

_____

Clinical History

YES NO Issues – *please provide details*

- ☐ ☐ Do you have a primary care provider? When was your last visit? _____
- Primary Care Provider: _____
- ☐ ☐ Nerve Problems: _____
- ☐ ☐ Kidney Problems: _____
- ☐ ☐ Stomach or Bowel Problems: _____
- ☐ ☐ Impotence Problems: _____
- ☐ ☐ Frequent Infections: _____
- ☐ ☐ Heart Problems: _____
- ☐ ☐ Sleep Problems: _____
- How many hours of sleep do you get on average? _____
- ☐ ☐ Lung/Breathing Problems: _____
- ☐ ☐ High/Low Blood Pressure: _____
- ☐ ☐ Stroke: (please note when) _____
- ☐ ☐ Arthritis: _____
- ☐ ☐ Do you have an eye doctor? When was your last visit? _____
- Eye doctor: _____
- ☐ ☐ Eye Problems: _____
- ☐ ☐ Do you see a podiatrist/foot doctor? When was your last visit? _____
- Foot doctor: _____
- ☐ ☐ Foot Problems: _____
- ☐ Bunions ☐ Calluses ☐ Corns ☐ Foot drop ☐ Hammertoes ☐ Overlapping Toes
- ☐ Neuropathy ☐ Thick toenails ☐ Structural Problems ☐ Open Sores ☐ Pain/Tingling
- ☐ ☐ Has your primary care provider ever examined your feet? When? _____
- ☐ ☐ Do you examine your feet daily?
- ☐ ☐ Do you see a dentist? When was your last visit? _____
- Dentist: _____
- ☐ ☐ Did you get the flu vaccine? When was your last? _____
- ☐ ☐ Did you get the shingles vaccines? When? _____

- ◯ ◯ Did you get the COVID19 vaccines? When? _____
- ◯ ◯ Are you pregnant? If so, when are you due? _____
- ◯ ◯ Are you planning to get pregnant? _____
- ◯ ◯ Did you have any complications during previous pregnancies? _____
- ◯ ◯ Do you wear a medical ID?
- ◯ ◯ Do you experience hyperglycemia (blood sugar of 350 or higher?) How often? _____

  How do you treat hyperglycemia? _____
- ◯ ◯ Have you ever had DKA (diabetes ketoacidosis)? When? _____
- ◯ ◯ Do you ever test for ketones?

  What do you do if you have ketones? _____
- ◯ ◯ Do you experience hypoglycemia or symptoms of low blood sugar? How often? _____
- ◯ ◯ Can you tell when you have hypoglycemia? _____

  How do you treat hypoglycemia? _____
- ◯ ◯ Do you keep a Glucagon Emergency Kit at home?
- ◯ ◯ My family/friends know how to use a Glucagon Emergency Kit

Knowledge Assessment:

Directions: Read each question and decide which choice best completes the statement or answers the question. Choose your answer by circling the correct letter.

1. Risk factors for type 2 diabetes include:
   - ◯ a. Eating high-sugar foods and sweets
   - ◯ b. High levels of physical activity
   - ◯ c. A family history of diabetes
   - ◯ d. An immune system that is working too hard
   - ◯ e. I do not know
2. Recommended target ranges include: 70 to 130 mg/dL fasting and before meals, and less than 180mg/dL 1 to 2 hours after start of meals. If at least half (50% of your glucose results are in the recommended target range, your A1C test should be:
   - ◯ a. Less than 6 percent
   - ◯ b. Less than 7 percent
   - ◯ c. Less than 8 percent
   - ◯ d. Less than 9 percent
   - ◯ e. I do not know

3. When diabetes starts, why do people with type 2 diabetes have high glucose levels?
   - a. Their pancreas has stopped making insulin completely
   - b. Their kidneys are not working properly
   - c. Their body cannot use insulin properly or their pancreas does not make enough insulin
   - d. The sweets they ate caused diabetes
   - e. I do not know
4. A common symptom of diabetes is:
   - a. Weight gain
   - b. Tiredness
   - c. A skin rash
   - d. A craving for sweets
   - e. I do not know
5. Eating for better health includes all of the following except:
   - a. Eating lots of fresh fruits and vegetables
   - b. Avoiding all foods with carbs
   - c. Being aware of portion sizes and choosing appropriate amounts of foods
   - d. Eating when hungry and stopping when satisfied
   - e. I do not know
6. Which statement is true about fat in foods?
   - a. An unlimited amount of saturated fat in your food plan is OK
   - b. A high fat diet can help with weight loss
   - c. Trans fats are good for your heart
   - d. Choosing unsaturated fats instead of saturated fats may reduce your risk for heart disease
   - e. I do not know
7. Which of the following is a way to practice eating mindfully?
   - a. Take 15-30 minutes to eat slowly and enjoy your food
   - b. Eat at a table
   - c. Use the hunger scale to help guide you when you eat and when to stop
   - d. All of the above
   - e. I do not know
8. How does physical activity usually affect your glucose level?
   - a. Lowers your glucose level
   - b. Raises your glucose level
   - c. Has little effect on your glucose level
   - d. None of the above
   - e. I do not know
9. Setting goals is a way to help you make positive life changes. Which is an example of a practical goal?
   - a. If you have never been physical active: "I will jog 5 miles a day, 5 days a week."
   - b. "I will lose 30 pounds in 2 months"
   - c. If you are already physically active: "I will jog 5 miles a day, 5 days a week"
   - d. "I will never forget to take my diabetes medication"
   - e. I do not know

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10. Symptoms of low glucose include:
    - a. Feeling shaky or sweaty
    - b. Dry skin
    - c. Feeling energetic
    - d. Dry mouth
    - e. I do not know
11. Treatment for low glucose is
    - a. ½ cup orange juice
    - b. 1 can regular soft drink
    - c. 1 full-size candy bar
    - d. 1 ounce peanuts
    - e. I do not know
12. Illness and emotional stress generally cause your glucose level to:
    - a. Rise
    - b. Fall
    - c. Stay the same
    - d. None of the above
    - e. I do not know
13. Which of the following is *not* a complication of diabetes?
    - a. Kidney problems
    - b. Lung problems
    - c. Nerve problems
    - d. Heart problems
    - e. I do not know
14. Good foot care for people with diabetes includes:
    - a. Removing corns and calluses
    - b. Soaking your feet
    - c. Going barefoot in your house
    - d. Checking your feet daily
    - e. I do not know
15. Some diabetes pills:
    - a. Resist the action of insulin
    - b. Help your body use insulin better
    - c. Contain insulin
    - d. None of the above
    - e. I do not know