3DIAB

HEALTH ASSESSMENT

Date _____

Name _____ DOB _____

Day phone _____ Best time to call _____ May we leave a message? _____

Occupation _____ Primary Language _____

Current Health Status: (circle one) Excellent Very good Good Fair Poor

Why has your doctor referred you here? _____

Do you have other health problems? Please check all that apply.

☐ High Blood Pressure ☐ Stroke ☐ Heart Disease ☐ Kidney Problems

☐ Thyroid Problems ☐ Previous Gestational Diabetes ☐ Prediabetes ☐ Diabetes

Other _____

List any surgeries you have had _____

Have you been in the hospital or Emergency Room in the past year? ☐ No ☐ Yes

If yes, please explain _____

Medications/Supplements/Vitamins _____

_____

_____

Do you have any medication allergies? ☐ No ☐ Yes If yes, what? _____

Do you have difficulty with:

Vision ☐ No ☐ Yes Explain _____

Hearing ☐ No ☐ Yes Explain _____

Speech ☐ No ☐ Yes Explain _____

Walking ☐ No ☐ Yes Explain _____

Do you use tobacco? ☐ No ☐ Yes If yes, how much? _____

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

Do you use recreational drugs? ☐ No ☐ Yes If yes, what? _____

When did you last see your physician? _____

Do you have any cultural or religious beliefs that need to be considered in planning your care? _____

_____

Do you have any financial concerns regarding your care? _____

PLACE PATIENT ID LABEL HERE

PROVIDENCE Alaska Medical Center

HEALTH ASSESSMENT

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Lifestyle History

Height_____ Weight _____

What time do you eat: Breakfast_____ Lunch_____ Dinner_____ Snacks _____

Do you follow any special diet? (i.e. low salt, low fat, gluten-free, etc.) ☐ No ☐ Yes
What kind of diet? _____

Who does the grocery shopping and cooking at your home? _____

How many times a week do you eat out?_____

How often do you exercise? ☐ Never ☐ once a week ☐ 2-3 x/week ☐ 4 or more x/week

Please tell us how you handle stress _____

Do you feel safe in your home? ☐ Yes ☐ No

Do you feel safe in your relationships with your family, companion, and/or friends? ☐ Yes ☐ No

For Patient with Diabetes:

How long have you had diabetes? _____

How has having diabetes changed the way you feel about yourself? _____

_____

What changes have you made since you found out you have diabetes?_____

_____

Who have you involved in your diabetes care?_____

Do you check your blood sugar levels? ☐ No ☐ Yes If yes, what meter? _____

What times of day do you check your blood sugar? _____

Do you check your feet daily? ☐ No ☐ Yes

Do you have any numbness or tingling in your feet? ☐ No ☐ Yes

How often do you see your dentist? _____

Have you had a **dilated** eye exam in the last year? ☐ No ☐ Yes

Has having diabetes affected your sexual health? ☐ No ☐ Yes

_____ ___

Last Menstrual Cycle:_____

For Patients with Gestational Diabetes:

Due Date: _____Previous Gestational Diabetes: ☐ Yes ☐ No

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