



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? _____

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PLACE PATIENT
ID LABEL HERE

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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

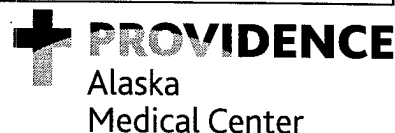
Last Menstrual Cycle: _____

For Patients with Gestational Diabetes:

Due Date: _____ Previous Gestational Diabetes: Yes No

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