



HEALTH SURVEY General Information

3PA

Name: _____ Date: _____

Birth date: _____ Age: _____ Best phone number _____ Best time to call _____

What is your preferred language? _____ spoken _____ written

Primary Care Doctor: _____ Diabetes Doctor: _____

Diabetes History

When were you diagnosed? _____

How do you feel about having diabetes? _____

Have you ever had diabetes education? Yes No When? _____ Where? _____

How would you rate your understanding of diabetes? Good Fair Poor

What type of diabetes do you have? Type 1 Type 2 Don't know

Any family members with diabetes? Yes No If yes, whom _____

Does anybody help you take care of your diabetes? Yes No Whom? _____

Medications

Please list the names of **ALL** medications (**Bring medications to appointment**)

Name	Dosage	When Taken

List Others: _____

Are you allergic to any medications? Yes No List: _____

If you take insulin, do you give your own injections? Yes No Explain: _____

11468 ODE 1588 (12/31/08)

Washington Hospital Healthcare System

Washington Township Healthcare District
2000 Mowry Avenue, Fremont, California 94538-1716 • (510) 797-1111

DIABETES PROGRAM PATIENT SELF ASSESSMENT

PATIENT LABEL

Medical History

What other conditions do you have?

- | | |
|--|----------------|
| <input type="checkbox"/> Blood pressure problems | Explain: _____ |
| <input type="checkbox"/> Kidney problems | Explain: _____ |
| <input type="checkbox"/> Heart problems | Explain: _____ |
| <input type="checkbox"/> Cholesterol problems | Explain: _____ |
| <input type="checkbox"/> Sexual problems | Explain: _____ |

Last eye exam? _____

Last foot exam? _____

Last dental checkup? _____

Do you smoke cigarettes? Yes No If yes, number of cigarettes each day? _____

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

Do you use illicit drugs? Yes No If yes, explain _____

Last pneumonia shot? _____ Last flu shot? _____

List major operations you've had: _____

Nutrition

What is your ideal weight? _____

Has your weight changed in the past year? Yes No _____ pounds (gained or lost?)

Do you have a history of an eating disorder? Yes No (describe) _____

Current diet _____ Who cooks? _____ Who shops? _____

How often do you eat out and where? _____

Do you follow a food plan? Type _____

What changes have you made in your diet recently, if any _____

List any food allergies or intolerances _____

List any cultural / religious diet restrictions you follow, if any _____

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Health Survey General Information

Diet History (what foods do you usually eat)

Breakfast	Lunch	Dinner
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Snacks:

Exercise

Have you been advised to limit exercise? Yes No (describe) _____
 Do you exercise on a regular basis? Yes No Type _____
 How many times a week do you exercise? _____ For how long? _____ minutes

Pain Assessment

Are you having any pain now? Yes No (skip this section)
 Where is the pain? _____ Describe _____

Pain Scale: (circle)

0	1	2	3	4	5	6	7	8	9	10
None	Mild	Moderate	Severe	Very Severe	Worst Possible					
Annoying	Uncomfortable	Distressing	Horrible	Excruciating	Agonizing					

What is your goal? comfortable increase function able to sleep reduce intensity
 Are you under the doctor's care for pain? Yes No

Monitoring

What do you consider a normal blood sugar reading? _____
 Most recent A1C value _____ % Date _____
 Do you test your blood sugar? Yes No If yes, what meter do you use? _____
 How often do you test? None 1-2 times day 3+ times day Other _____
 What time(s) of the day? breakfast lunch dinner bedtime
 2 hours after meals other _____
 Usual blood sugars? Before meals _____ Two hours after meals _____

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**DIABETES PROGRAM
PATIENT SELF ASSESSMENT**

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Health Survey

Lows

Have you ever had low blood sugars? Never Previously In the last week

What symptoms did you have? _____

Do you wear a medical identification bracelet or necklace? Yes No

Have you ever been unconscious from low blood sugars? No Yes When? _____

Can you tell when your blood sugar is too low? Yes No

How do you treat a low blood sugar? _____

Highs

Have you ever had high blood sugars? Yes No Highest reading _____

Do you test for urine ketones? Yes No

Pregnancy

Are you pregnant? Yes No Expected due date? _____

Are you planning to become pregnant? Yes No N/A Birth control method? _____

Social History

Describe any stress in your life and how you handle it _____

How do you learn best? Reading Demonstration Hands on Watching TV

Tell us anything you feel may interfere with your ability to learn: _____

Do you have difficulty with? Hearing Speech Vision Explain: _____

Marital Status: Single Married Significant Other Divorced Widowed

(Optional) Race _____ (for data collection purposes only)

Last Grade in School? _____ Number in Household? _____

Do you work? Yes No If yes, type of work? _____ Work hours? _____

Is there anything else you would like us to know about you? _____

Your expectations of our Diabetes Program _____