

Living Healthy with Diabetes

A Self-Management Education Program



United Memorial
Medical Center

Quality care right at home.

INITIAL ASSESSMENT/CLASS REGISTRATION

Please complete this form and send to: **United Memorial Medical Center, Healthy Living, 211 East Main Street, Batavia, NY 14020.** Or, you may bring it to your first class. If you need assistance, bring the form to class and someone will help you.

GENERAL INFORMATION

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ email: _____

Physician: _____

What is your race? White Black Native American Asian/Pacific Islander Hispanic

Primary Support Person (Spouse, Children, etc.) _____

Do you live alone? Y N

Occupation: _____ Shift: Days Evenings Nights

Number of Years School Completed: _____

Possible Barriers to Learning: (Please check any that apply to you)

Vision Problems Language (English not spoken/understood well) Hearing Problems Literacy

Other (Please describe): _____

MEDICAL INFORMATION

Height _____ Weight _____

Describe any weight change in the last 6 months:

Gain _____ lbs Loss _____ lbs Was this change intentional? Y N

Allergies? Y N If yes, please list: _____

When did you first learn that you have diabetes? _____

Have you had any previous diabetes instruction? Y N If yes, when? _____ Where? _____

Does anyone in your family have diabetes? Y N If yes, who? _____

See reverse >>

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Please list all medications you are currently taking, dose, and when you take them:

Medicine	Dose	When you take
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any of the following? (Please check all that apply)

- High Blood Pressure Heart Problems High Cholesterol/Triglycerides Eye Problems
 Numbness or tingling in feet Kidney Problems Decreased Circulation

Other: _____

Do you test your blood sugar at home? Y N

Do you smoke? Y N Number of packs per day: _____

How often do you consume an alcoholic beverage? _____

How much do you drink at one time? _____

Do you exercise regularly? Y N Type/Frequency: _____

Do you see your doctors regularly?

Primary Physician? Yes, How often _____ No

Ophthalmologist (eye doctor)? Y N

Do you see a diabetes specialist? Y N

Have you been admitted to the hospital in the last year? Y N

If yes, please explain _____

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YOUR THOUGHTS

What is the hardest thing for you about having diabetes? _____

Please check any specific areas that you would like to improve or learn more about concerning your diabetes:

- Understanding Diabetes Medications Managing Stress Meal Planning Exercise
 Blood Sugar Testing Support Services Available Effects of Diabetes on the Body
 Hypoglycemia/Hyperglycemia (Low/High Blood Sugar)

List ONE change that you want to work on over the next 1-3 months. Please be very specific. (examples: I will test my blood sugar once a day, 7 days/week, or, I will walk for 20 minutes, 3 days/week.)

EATING HABITS

Do you follow a special diet? Y N What kind? _____

Who does the shopping/cooking at home? _____

How many times per month do you eat at each type of restaurant?

Fast Food/Take Out: _____ Sit Down: _____ Buffet: _____

See reverse >>

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Please write down everything you eat in a typical day. Write the amounts eaten (1 cup, 3 oz, 1 teaspoon, etc.). Be sure to include all beverages.

Breakfast	Lunch	Dinner	Snacks
Time: _____	Time: _____	Time: _____	Time: _____
			Time: _____
			Time: _____

Do you have any special religious or cultural needs relating to food? Y N If yes, please explain: _____

Please list any food allergies, intolerances, or dislikes. _____

Thank you for taking the time to complete this form. This information will help us meet your specific needs relating to your diabetes care. We look forward to seeing you in class!