Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Email Address: _____

Primary Physician: _____

DuPage Medical Group

WE CARE FOR YOU

PEDIATRIC Diabetes Assessment form

General Information

Ethnicity:

□Caucasian □ African American □ Hispanic □Native American □Asian □ Middle Eastern

Language preference: □English □Other _____

Education: What school do you attend?_____ Grade?_____

Employment: Do you have a job? □ YES □ NO

If yes, what do you do?_____ What are your typical work hours?_____

Support System: Who helps you with managing your diabetes?

□Family □Friends □Healthcare providers □Support group □No-one

Learning Style: Are there any things we should know about that would interfere with your ability to learn?

□None □Hearing □Visual □Reading □Language □Psychological □Other - _____

How do you learn best? □Reading □Doing □Observing/Listening □Classes □Films □Computer

Cultural / Religious Beliefs:

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?

□No □Yes If yes, please describe_____

Medical History

Past or Current medical issues:	Yes	No	?	Past or Current medical issues:	Yes	No	?
Eye/Vision problems (blurring, spots etc.)				Gum disease			
Foot problems (blisters, fungus, pain, numbness etc.)				Frequent infections			
Kidney problems				Depression			
High cholesterol				Other			
High Blood pressure							

Diabetes – date of diagnosis: (month/year)_____ **Is your diabetes:** □ Type 1 □ Type 2 □ Not sure

Dental – date of last exam: (month/year)_____ **Allergies:** □ Food □ Medication □ Other List:_____

Hospitalizations: How many times have you been hospitalized? _____

Reason(s)_____

Emergency Room: How many times have you been to the ER? _____

Reason(s)_____

Prescription Medications:	**Record the information as it is written on your medication containers**				
Name	**Dose**	**What is it for?**	**Start Date**	**Amount Taken**	**When Taken**
(example)Singulair	*4 mg*	*Asthma*	*3/5/03*	*1 tablet*	*At bedtime*

Nonprescription Medications:							
	Yes	No	Comment:		Yes	No	Comment:
Allergy meds				Laxatives			
Cough/Cold meds				Diet pills			
Aspirin/Pain relief				Vitamins/Mineral			
Antacids				Other:			

Diabetes and Lifestyle Management

Blood Sugar Testing

Do you currently check your blood sugar? At home? □ YES □ NO At work/school? □ YES □ NO

What brand of meter do you have?_____ How often do you test?_____ times each day/week (circle one)

Hypoglycemia

How often do you experience a low blood sugar? _____ Can you sense a low sugar? □Always □ Sometimes □ Rarely

What are your symptoms of a low blood sugar?_____, _____, _____, _____

How do you treat your low blood sugars?_____

Do you keep glucagon at home? □ YES □ NO If yes, what is the expiration date?_____

Activity

Do you have PE / Gym at school? □ YES □ NO If yes, at what time?_____

Do you get activity on a regular basis? □ YES □ NO

How much activity / sports do you do per day? □ None □ 1-30 min □ 30-60 min □ 60+ min

What type of activity do you do?_____

Are there any medical reasons that limit / stop (circle one) you from daily activity? □ YES □ NO Explain:_____

Miscellaneous

Within the last year, how many days of school / work have you missed due to diabetes? _____

How would you rate your stress level? □ Low □ Moderate □ High

During the past month, have you often been bothered by feeling down, depressed, or hopeless? □ YES □ NO

During the past month, have you often been bothered by little interest or pleasure in doing things? □ YES □ NO

Do you wear medical identification? □ YES □ NO What type?_____

What time do you wake up?_____ What time do you go to sleep?_____ Nap time(s)?_____

Day Care? □ YES □ NO Other caregivers:_____

Insulin History

(Skip this section if you are not taking insulin)

Insulin vial/syringe or Insulin pen users: *(if you use an insulin pump, skip this section)* □ **Pen** □ **Vial/Syringe**

Do you adjust your own insulin doses? □ YES □ NO Did your doctor give you a scale to use for adjustments? □ YES □ NO

If you use a scale, what is the scale?_____

_____

Who gives you your injections?_____

What sites do you use to give yourself insulin injections? _____, _____, _____

Does insulin or blood ever come out of the injection site? □ YES □ NO If yes, how often?_____

Where do you store your extra insulin bottles?_____ Where do you store the insulin you are currently using?_____

When do you change your insulin pen or vial? □ When Empty □ Monthly

Do you give an air shot to prime the pen needle with insulin prior to dialing up your insulin dose?(*Pen users only)* □ YES □ NO □ Don't know

How do you dispose of your syringes, lancets, or pen needles?_____

INSULIN TYPE	# OF UNITS	TIME OF DAY

Insulin pump users: *(If you use an insulin pen or vial/syringe skip this section)*

What type of pump do you have? _____ How long have you had this pump?_____

What infusion set do you use?_____ Do you use advance pumping features? □ YES □ NO □ Don't know

Do you use a continuous glucose monitor? □ YES □ NO If yes, type?_____ If no, are you interested in one? □ YES □ NO

Pump settings: Time____ Rate____; Time____ Rate____; Time____ Rate____; Time____ Rate____; Time____ Rate____

Insulin to Carb Ratio? _____ / □ don't use Sensitivity Factor: _____ Target blood sugar range: _____

Nutrition Assessment

Height: ________ **ft** ________**inches** **Current Weight:**_____________ **Desired Weight:**_________________

In the past month have you: ☐ Lost Weight ☐ Gained Weight # lbs lost/gained:__________ ☐ No Change

If you lost weight was it: ☐ Intentional ☐ Unintentional

Do you have any diet restrictions? (include allergies and intolerances) ____

____

Have you ever adjusted your insulin to influence your body weight? ☐ YES ☐ NO

Give a sample of your meals for a typical day (If you brought in a food log, give it to the dietitian and go to the next question)

Time: ____________ Breakfast: ____

Time: ____________ Snack: ____

Time: ____________ Lunch: ____

Time: ____________ Snack: ____

Time: ____________ Dinner: ____

Time: ____________ Snack: ____

Is it hard to control what you eat? ☐ YES ☐ NO

How many times do you eat out? ☐ 0-1 ☐ 2-4 ☐ 5-8 ☐ Daily

Do you skip meals? ☐ No ☐ Sometimes ☐ Yes If yes, how often? ______ times per week

How often do you eat the following foods?

Fruit	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Fruit Juice	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Vegetables	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Red Meat	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Fish	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Fried foods	☐ daily/often	☐ occasionally	☐ rarely	☐ never					
Milk	☐ daily/often	☐ occasionally	☐ rarely	☐ never	**Kind?**	☐ Skim	☐ 1%	☐ 2%	☐ Whole
Soda	☐ daily/often	☐ occasionally	☐ rarely	☐ never	**Kind?**	☐ Regular	☐ Diet		

How many 8 oz glasses of water do you drink daily? ☐ 0-1 ☐ 2-4 ☐ 5-8 ☐ 9+

Do you drink alcohol? ☐ NO ☐ YES If yes, what type? __________ Amount ________ per day/week (circle one)

Do you use tobacco? ☐ NO ☐ YES If yes, what type? __________ Amount ________ per day/week (circle one)

Patient/Parent Signature: ____________________________________ **Date:**______________________________

Mother's name: _____________________________ **Father's name:** _____________________________

For divorced parents: Who does the child spend most time with? ☐Mother ☐Father Specify:_______________________

Daytime phone:______________________________ Whose phone number is this?__________________

Evening phone:______________________________ Whose phone number is this?__________________

Email address:______________________________ Whose email is this?__________________

Do you prefer contact by mail or phone? ☐ phone ☐ email ☐ no preference

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For Diabetes Center:

Assessment reviewed by: _______________________________RN, CDE Date: ______________________

_______________________________RD, CDE Date: ______________________