NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

DIABETES SELF-ASSESSMENT

Name: _____ DOB: _____
Phone: _____ Cell/Work _____ Email: _____
Referring Physician: _____

Personal History:
What is your primary language? _____ Language spoken at home _____
Do you have any spiritual/cultural practices that you would like us to include in your care today? ___Yes ___No
Have you had any difficulty caring for yourself at home over the past 3 months? ___Yes ___No
Is anyone in your personal life hurting you or making you feel unsafe? ___Yes ___No
Do you have a health care proxy? ___Yes ___No
Learning Needs Assessment:
How do you learn best? ___by doing ___by reading ___by listening (verbal)
Do you have any trouble understanding written or verbal instructions? ___Yes ___No

Health Status:
Do you have any food allergies to: Medications? Y N Food? Y N Latex? Y N Other _____
Do you have or have had a problem with the following conditions?
__High blood pressure
__High cholesterol
__Heart disease/chest pain
__Stroke
__Kidney disease
__Anxiety/depression
__High or low blood sugars
__Poor circulation
__Foot problems or pain/tingling/numbness
__Eye disease or cataracts/glaucoma
Do you have any other medical conditions? _____
Pain Assessment
How do you rate your tolerance to pain? ___Low ___Average ___High
Do you have pain now? ___Yes ___No Where is it located? _____
Is your pain: Constant or Comes and Goes (Intermittent)
On a scale of 1-10, with 0 being no pain and 10 being the highest rate of pain, rate what is your pain right now?
1 2 3 4 5 6 7 8 9 10
Fall Risk
Have you fallen in the last 6 months (not from a slip or trip) ___Yes ___No
Are you feeling weak, dizzy, or lightheaded today? ___Yes ___No
Do you need help to walk or change your clothes? ___Yes ___No
Have you every been lightheaded or dizzy before or after having blood drawn or an IV started? ___Yes ___No

Health Habits:
Do you smoke? ___Yes ___No If yes, how much? _____
Do you drink alcohol? ___Yes ___No If yes, how much? _____
Do you use street drugs or narcotics? ___Yes ___No If yes, how much? _____
Do you have an eye exam every year? ___Yes ___No If yes, date of last exam: _____
Do you see a regular doctor every year? ___Yes ___No If yes, date of last exam: _____
Do you see a dentist every year? ___Yes ___No If yes, date of last exam: _____

Diabetes History:
How long have you had diabetes? _____ What was your last HgA1c result? _____
Have you ever received any education related to diabetes? _____
Do you check your blood sugars regularly? ___Yes ___No How often? _____
Diabetes Medications
Do you take Diabetes Pills? ___Yes ___No Insulin? ___Yes ___No Insulin pump? ___Yes ___No
If yes, please list name, dose and times: _____

Exercise & Nutrition:
What do you do for exercise? _____ How often? _____
Current Weight: _____ and Height: _____
Have you had any weight changes in the past 3 months? ___Yes ___No
If yes, please describe _____
Please list all vitamins, minerals, or supplements you currently take: _____

In regards to your diabetes management, what would you like to learn today?

_____
_____
_____

Signature:_____ Date:_____ Time:_____