von Arx Diabetes Center of Excellence & Nutrition Health

PATIENT DEMOGRAPHIC INFORMATION

PATIENT INFORMATION

PATIENT NAME:	DATE OF BIRTH:	AGE:
PERMANENT ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBERS: HOME:	WORK:	CELL:
SOCIAL SECURITY NUMBER: - -	# OF PERSONS IN YOUR HOUSEHOLD:	
GENDER: ☐ F ☐ M	MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED	
E-MAIL ADDRESS:	RELIGIOUS PREFERENCE:	
COUNTRY OF ORIGIN (BIRTHPLACE):	LANGUAGE PREFERENCE:	
EMPLOYER (OR FORMER):	PHONE NUMBER:	
OCCUPATION:	☐RETIRED	
STUDENT: SCHOOL NAME:	LAST GRADE COMPLETED:	YEAR:
ANY DISABILITIES WE SHOULD BE AWARE OF (IF YES, PLEASE EXPLAIN):		
MILITARY VETERAN: ☐ YES ☐ NO	BLACK LUNG BENEFITS: ☐ YES ☐ NO	100% DISABLED: ☐ YES ☐ NO

EMERGENCY CONTACT INFORMATION

NAME:	RELATIONSHIP:	GENDER: ☐F ☐M
ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBERS: HOME:	WORK:	CELL:

ALTERNATE HOME ADDRESS

☐ PLEASE CHECK THIS BOX IF YOUR ADDRESS IS THE SAME ALL YEAR

ALTERNATE ADDRESS:		
CITY:	STATE:	ZIP CODE:
PHONE NUMBERS: HOME:	WORK:	CELL:

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PATIENT MEDICAL INFORMATION

PATIENT INFORMATION

PATIENT NAME:	
# OF PERSONS IN YOUR HOUSEHOLD:	WILL ANYONE BE ASSSITING YOU IN YOUR DIABETES CARE? : ☐ Y ☐ N

CULTURAL INFLUENCES AND SPECIAL DIETARY NEEDS

1. DO YOU HAVE ANY RELIGIOUS OBSERVATIONS?:
2. WHAT IS YOUR LANGUAGE PREFERENCE?:
3. DO YOU TAKE HERBAL OR NUTRITION SUPPLEMENTS / VITAMINS?: ☐ Y ☐ N

IF SO, WHAT KIND, ETC.:

MEDICAL HISTORY

1. WHEN WAS YOUR LAST PHYSICAL EXAM?

2. HOW OFTEN DO YOU HAVE YOUR EYES CHECKED?:	DATE OF LAST EXAM?:
3. HOW OFTERN DOYOU HAVE A DENTAL CHECK UP?:	DATE OF LAST CHECK UP?:
4. DO YOU SMOKE?: ☐ Y ☐ N	IF SO, HOW MUCH?:
5. DO YOU HAVE ANY ALLERGIES?: ☐ Y ☐ N	IF YES, TO WHAT?
6. HAVE YOU EVER HAD A PNEUMONIA SHOT?: ☐ Y ☐ N	FLU SHOT?: ☐ Y ☐ N

7. PLEASE LIST ANY MEDICATIONS THAT YOU ARE ON:

8. DO YOU HAVE ANY OF THESE MEDICAL CONDITIONS?:	☐ HIGH BLOOD PRESSURE	☐ HEART DISEASE	☐ KIDNEY PROBLEMS	☐ HIGH CHOLESTEROL

☐ OTHER MEDICAL CONDITIONS:

DIABETES HISTORY (IF APPLICABLE)

1. HOW LONG HAVE YOU HAD DIABETES?:
2. WHAT TYPE OF DIABETES DO YOU HAVE? : ☐ TYPE 1 ☐ TYPE 2 ☐ GESTATIONAL ☐ DO NOT KNOW

3. HOW OFTEN DO YOU CHECK YOUR FEET?:	DATE OF LAST EXAM BY DOCTOR?:

4. LIST ANY FAMILY MEMBERS WITH DIABETES:
5. IN YOUR OWN WORDS, WHAT IS DIABETES?:
6. HOW WOULD YOU RATE YOUR UNDERSTANDING OF DIABETES?: ☐ GOOD ☐ FAIR ☐ POOR
7. HAVE YOU EVER BEEN INSTRUCTED ON DIABETES CARE?: ☐ Y ☐ N

IF YES, WHEN?:	SESSION TYPE: ☐ CLASS ☐ INDIVIDUAL

8. WHAT AREAS OF DIABETES WOULD YOU LIKE TO LEARN MORE ABOUT?

☐ WHAT IS DIABETES?	☐ PILLS FOR DIABETES	☐ HIGH BLOOD SUGAR	☐ LOW BLOOD SUGAR	☐ DIET	☐ EXERCISE
☐ STRESS	☐ SICK DAYS	☐ PREGNANCY/DIABETES	☐ BLOOD TESTING	☐ COMPLICATIONS	☐ INSULIN PUMPS

9. WHAT IS YOUR GOAL FOR THIS EDUCATION SESSION?

☐ LEARN MORE ABOUT DIABETES	☐ HELP WITH MEAL PLANNING
☐ BETTER BLOOD SUGAR CONTROL	☐ WEIGHT MANAGEMENT

☐ OTHER