Diabetes and Endocrine Associates of Tarrant County, L.L.P.

DIABETES CARE RECORD **Today's Date** _____

Name _____ DOB _____ Age _____

List other household members: _____

DIABETES HISTORY

Length of time you have had diabetes _____

Present treatment plan includes (circle) Diet Exercise Pills Insulin Insulin pump

List relatives with diabetes _____

List medications you take _____

Current medical problems _____

Other doctors _____

When was the last time you were sick or in the hospital? _____

PHYSICAL ACTIVITY

Do you have a regular exercise plan outside of work? _____

What type: _____ How often? _____

How long? _____

Do you consider it (please circle) Strenuous Mild Light?

MEAL PLAN AT HOME *Give a sample of meals for a typical day or what you had to eat yesterday*

Time _____ Breakfast _____

_____

_____ Drink _____

Time _____ Snack _____

Time _____ Lunch _____

_____

_____ Drink _____

Time _____ Snack _____

Time _____ Supper _____

_____

_____ Drink _____

Time _____ Bedtime Snack _____

_____ Drink _____

What do you like to snack on? _____

How often do you eat out? _____ Where? _____

What is your typical meal selection at these places? _____

MONITORING CONTROL

Do you test your blood glucose at home? Yes ☐ No ☐ Name of meter(s) _____

How often do you test and when? _____

Average before breakfast result _____ Before lunch _____ Before supper _____

Before bedtime _____ At what level do you feel that your blood glucose is low? _____

Are you familiar with a sick day routine? _____

Do you take preventative vaccines (example: flu shot)? _____

COMPLICATIONS

When was your last EKG/Stress Test? _____

Please circle and describe problems with any of the following

Eyes	***Kidneys***	***Heart***	***Blood pressure***	***Numbness or tingling in hands***
Foot *(sores, corns, numbness, pain)*	***Stomach Function***	***Sexual Function***	***Infections****(skin, feet gums, mouth, vaginal)*	***Nerves***

MEDICATIONS

Oral Agents / Hypoglycemia Pills

Name of medication(s): _____

Amount: _____

Time(s) taken: _____

Insulin Injections

Injection Sites: _____

Insulin Type: _____ Amount: _____ Time: _____

Insulin Type: _____ Amount: _____ Time: _____

Insulin Type: _____ Amount: _____ Time: _____

Insulin Type: _____ Amount: _____ Time: _____

Insulin Pump / Continuous Glucose Monitoring System (CGMS)

Pump Type: Medtronic Animas Omnipod T-slim Dexcom Other: _____ Year: _____

Infusion Set Type: _____ Changed: _____ days

CGMS?: _____ Year: _____ CGMS changed: _____ days

Do you download your devices at home to Diasend? Yes ☐ No ☐

Insulin to Carb Ratio: Breakfast: _____ Lunch: _____ Supper: _____

Insulin Sensitivity: _____

Insulin Type: _____

Insulin on Board: _____ Hours Total Daily Dose: _____

Basal Amount: _____ Time: _____

Basal Amount: _____ Time: _____

Basal Amount: _____ Time: _____

Basal Amount: _____ Time: _____

Basal Amount: _____ Time: _____

Basal Amount: _____ Time: _____

EDUCATION FOR SELF-MANAGEMENT SKILLS

When was your last diabetes instruction class? _____

When was your last eye exam? _____ Doctor _____

When was your last dental exam? _____ Doctor _____

When was your last foot exam? _____ Doctor _____

Do you use alcohol? _____ How much? _____

What is the most difficult aspect for you concerning your diabetes? _____

Who are your support people? _____

What would you like to learn about living with diabetes? _____

DIABETES EDUCATOR'S NOTES