TMH PHYSICIAN PARTNERS

The Diabetes Education Programs of the
TMH Physician Partners - Metabolic Health Center
2633 Centennial Blvd, Suite 100
Tallahassee, Fl. 32308
(850) 431- 5404/Fax 431-4838

Dear Patient:

We would like to welcome you to the Diabetes Education Programs of the Metabolic Health Center! Our program was established to help people learn how to control their diabetes. Our staff of certified diabetes educators will help you learn about diabetes and the tools you need to manage it successfully.

Once we receive a completed referral from your doctor, we will call to schedule your appointment. Please bring the appropriate paperwork (registration packet **and** patient history forms) and provide it to our front office staff at the time of your first appointment. Also, bring your insurance card(s), photo identification, and blood glucose machine if you have one. If you are unable to complete the paperwork before your scheduled appointment, please call us to reschedule.

Please note that your insurance company will be billed for these services unless other arrangements were made before your scheduled appointment. You will be responsible for any non-covered benefits, unmet deductible, co-payment, or coinsurance. Should you have any questions regarding insurance coverage, please call your insurance company directly first and let them know that we are a hospital outpatient facility and the procedure code is G0108 (diabetes education). After speaking with your insurance company, if you have any additional questions, please do not hesitate to call us.

If you have any questions or need to change your appointment time or date, please contact our office at 850/431-5404, option 3. If you need to cancel your appointment, please let us know 24 hours in advance so that we may accommodate patients waiting for an appointment. (You also may be asked to reschedule your appointment if you arrive 10 minutes late.)

We look forward to meeting you and helping you manage your diabetes.

Sincerely,

TMH Physician Partners - Metabolic Health Center

TALLAHASSEE MEMORIAL METABOLIC HEALTH CENTER
DIABETES HEALTH HISTORY- ADULT

Name: _____ Date of birth:_____

MEDICAL HISTORY

When were you diagnosed with diabetes? _____

What type of diabetes do you have? □ Type 1 □ Type 2 □ Pre-diabetes □ Unsure

Do you use an insulin pump? □ YES □ NO Brand of pump_____

Do you test your blood sugar or use a continuous glucose monitor (CGM)? □ YES □ NO If yes, what meter do you use?

_____ How often do you test?_____ CGM type: _____

Do <u>you</u> have any of the following complications of diabetes or other medical conditions?

□ Eye problems (Specify: _____) □ Heart disease □ Peripheral artery disease (PAD or PVD)

□ High blood pressure □ Foot problems (Specify: _____) □ Amputation (Location:_____)

□ Neuropathy □ Kidney problems □ High cholesterol/triglycerides □ Arthritis □ TB □MRSA □ Thyroid problems

□ Liver disease □ Erectile dysfunction □ Cancer (Specify: _____) □ Sleep apnea

□ Asthma/breathing problems □ GERD/acid reflux □ Gastroparesis □ Depression/anxiety □ Other Mental Health issues

□ Epilepsy □ Hypoglycemia episodes (How often/what time of day: _____)

□ Other (Please specify: _____)

List sources of stress in your life: _____

Consider the degree to which each of the two items below may have distressed or bothered you and circle the appropriate number:

	Not a problem	Slight problem	Moderate problem	Somewhat serious problem	Serious problem	Very serious problem
Feeling overwhelmed by the demands of living with diabetes.	1	2	3	4	5	6
Feeling that I am often failing with my diabetes routine.	1	2	3	4	5	6

List any surgeries that you have had and the year of each:

_____

_____

Have you been to the Emergency Room or hospitalized during the past 12 months? □ Yes □No

(If yes, please explain: _____)

LIFESTYLE / HABITS

Have you changed your eating and/or exercise habits since finding out that you have diabetes? □ YES □ NO

Has your weight changed in past year? □ YES□NO (Please specify: _____)

Are you allergic to any foods? □YES □ NO (Specify: _____)

Are you following a diet? □YES □ NO (Please specify: _____)

Please describe your experience with diets in the past_____)

Please fill out the back too ↓

DIABETES HEALTH HISTORY-PAGE 2

Name: _____ Date of birth:_____

Have you identified problems with your eating habits? □ YES □ NO (Specify: _____)

How often do you eat out? _____ times per week (Specify: _____fast foods; _____buffets; _____sit-down restaurants)

Do you drink sugar- sweetened beverages (Gatorade, Kool-Aid, sweet tea, soda, etc.)? □ YES □ NO

Have you been advised by your health care provider/physician to be physically active? □YES □NO

□Restrictions:_____

Please rate your daily activity level: □ Mild □ Moderate □ Active Do you have a regular exercise program? □ YES □ NO

What do you do for exercise?_____ How often do you exercise?_____

How many alcoholic drinks do you have per week? _____

Do you smoke or chew tobacco? □ YES □ NO (Amount per day: _____)

Do you use recreational drugs (ex: Marijuana)? □ YES □ NO (Type/how often? _____)

SOCIAL HISTORY AND LEARNING CONSIDERATIONS

Occupation: _____Work hours: _____

Number of persons in your household: _____ Relationship and age(s): _____

_____

Do they help you in caring for your diabetes? □ YES □ NO (Explain: _____)

Are you in a family situation in which you fear for your safety? □ YES □ NO

Are you having difficulty with the costs of Diabetes medication and supplies? □ YES □ NO

Have you had diabetes teaching before? □ YES □ NO (Where/when? _____)

What do you want to learn about managing diabetes? _____
_____

Please specify any religious/cultural or personal health beliefs that you would like considered as we help you develop your diabetes care plan: _____

Please circle one answer to the statements below:

Within the past 12 months we worried whether our food would run out before we got money to buy more.
Often True Sometimes True Never True for your household

Within the past 12 months the food we bought just didn't last and we didn't have money to get more.
Often True Sometimes True Never True for your household

In what areas are you ready to make changes (if any)?
□ Nutrition □ Physical activity □ Blood glucose monitoring □ Diabetes medication □ Stress management

Health History form completed by: □ patient □ family member: _____ Date: _____