TMH PHYSICIAN PARTNERS

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 you 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____)

rev. 10/19

Please fill out the back too ↓

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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 <u>sugar- sweetened</u> 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? ______________________________________)

<u>SOCIAL HISTORY AND LEARNING CONSIDERATIONS</u>

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: ______________________