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 PP Metabolic Health Center Administration

TMH PP- METABOLIC HEALTH CENTER
DIABETES EDUCATION AND SELF-MANAGEMENT QUESTIONNAIRE

Name: _____ **Date of birth:** _____ **Age:** _____ **Race:** _____

❒ **Male** ❒ **Female What language do you prefer to use in discussing your health care?** ❒**English** ❒**Other** _____

Preferred contact number_____ **(work/home/cell) Alternate contact number**_____ **(work/home/cell)**

Address: _____

Name of emergency contact: _____ **Phone:** _____

Primary Care Physician: _____ **Referring Physician:** _____

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

MEDICAL HISTORY

When were you diagnosed with diabetes? _____ ❒ **Type 1** ❒ **Type 2** ❒ **Pre-diabetes** ❒ **Unsure**

Do you have a family history of diabetes? ❒ **YES** ❒ **NO**

Treatment for diabetes: ❒ **Diet/exercise alone** ❒ **Pills** ❒ **Insulin** ❒ **Pills and insulin** ❒ **Pump**

Do you have any questions about your medication? ❒ **YES** ❒ **NO**

Do you test your blood sugar at home? ❒ **YES** ❒ **NO (Meter type:** _____**Test times:**_____**)**

What problem, if any, do you have with blood sugar testing: _____

Do you have any of the following complications of diabetes or other medical conditions?

❒ **Foot problems (Specify:** _____**)** ❒ **Heart disease** ❒ **Hypertension** ❒ **High cholesterol/triglycerides**
❒ **Eye problems (Specify:** _____**)** ❒ **Arthritis** ❒ **Kidney** ❒ **TB** ❒ **MRSA** ❒ **Thyroid problems**
❒ **Cancer (Specify:** _____**)** ❒ **Neuropathy** ❒ **Sleep apnea** ❒ **Asthma/breathing problems**
❒ **Depression/anxiety** ❒ **Erectile dysfunction** ❒ **Liver disease** ❒ **Epilepsy** ❒ **Mental health issues** ❒ **GERD/acid reflux**
❒ **Other (Specify:** _____**)**

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

_____

_____

Have you been hospitalized during the past 12 months? ❒**Yes** ❒**No (Please explain:** _____

_____**)**

When did you last have your feet checked by a doctor? _____

How often do you inspect your feet? ❒ **Daily** ❒ **Few times a week** ❒ **Once a week** ❒ **Sometimes** ❒ **Rarely**

When did you last see an eye doctor for a dilated eye exam? _____

For women of child-bearing age, do you use birth control? ❒ **YES** ❒ **NO** ❒ **Does not apply to me Do you plan to become pregnant in the next year?** ❒ **YES** ❒ **NO Have you received any diabetes pre-pregnancy information?** ❒ **YES** ❒ **NO**

Patient Name: _____ **DOB:** _____

SOCIAL HISTORY

Occupation: _____ **Work shift:** _____

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

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

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

What do you want to learn in diabetes class? _____

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

Hobbies/Interests: _____

How do you learn best? ❒ Reading ❒ Listening ❒ Demonstration ❒ Hands-on ❒ Other: _____

How does having diabetes make you feel? _____

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

HABITS

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
Do you smoke or chew tobacco? ❒ YES ❒ NO (Amount per day: _____**)**
Do you use recreational drugs (Marijuana _____**)? ❒ YES ❒ NO (How often?** _____**)**
How many alcoholic drinks do you have per week? _____

NUTRITION

Has your weight changed in the last year? ❒ Gained: _____ **pounds ❒ Lost:** _____ **pounds ❒ Goal weight:** _____ **pounds**

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

Have you changed your eating habits since finding out that you have diabetes? ❒ YES ❒ NO

Are you following a diet? ❒YES ❒ NO (Specify: _____**) Please list your experience with diets in the past:** _____

How often do you eat out? _____ **times per week (Specify:** _____**fast foods;** _____**buffets;** _____**sit-down restaurants)**

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

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

Assessment completed by ❒patient ❒family member ❒clinician

CLINICIAN SIGNATURE/INITIALS _____ **DATE:** _____

For Office Use Only
ICD-10- Code: _____

PATIENT MEDICATION and SUPPLEMENT LIST

Name:_____ **DOB:**_____ **Physician:**_____
Pharmacy:_____
Medication Allergies:_____

Medication name	Dose	Taken by	Frequency (times per day)
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
		□ mouth □ injection □ inhaled □ _____	
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Reviewer Signature/Date/Time

** Notice to Patient** Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your Primary Care Physician.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____