

**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

TMH PHYSICIAN PARTNERS - 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)
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
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		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	
		<input type="checkbox"/> mouth <input type="checkbox"/> injection <input type="checkbox"/> inhaled <input type="checkbox"/> _____	

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.
