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

Rev 05/17
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.

<table>
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<tr>
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<th>Not a problem</th>
<th>Slight problem</th>
<th>Moderate problem</th>
<th>Somewhat serious problem</th>
<th>Serious problem</th>
<th>Very serious problem</th>
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<tbody>
<tr>
<td>Feeling overwhelmed by the demands of living with diabetes.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td>6</td>
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<tr>
<td>Feeling that I am often failing with my diabetes routine.</td>
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<td>2</td>
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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 □ Other: _____________________________

Do you have a regular exercise program? □ YES □ NO □ Other: _________________________________

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: __________
PATIENT MEDICATION and SUPPLEMENT LIST

Name:__________________________________  DOB:______________   Physician:____________________________
Pharmacy:________________________________________________________________________
Medication Allergies:____________________________________________________________________________

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<th>Medication name</th>
<th>Dose</th>
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<th>Frequency (times per day)</th>
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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.