

Name:

Date:

PHYSICAL ASSESSMENT HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE CORRECT BOX OR FILLING IN THE UP-TO-DATE INFORMATION. INFORMATION SHOULD RELATE TO THE LAST FEW WEEKS UNLESS OTHERWISE INDICATED.

HEALTH QUESTIONS	YES	NO	COMMENTS
Any headaches?			
Any sore or bleeding gums?			
Do you wear dentures?			
Any unusual dryness of skin? Heel cracks?			
Any rash or unusual discoloration to the skin?			
Any feelings of being too hot or too cold?			
Any chest pain or feelings of chest tightness?			
Any numbness, tingling, burning, or pain in feet or hands?			
Any difficulty breathing or shortness of breath?			
Any dizziness when standing?			
Any abdominal cramps, diarrhea, or constipation?			
For women, do you have vaginal discharge?			
Women please list the date of your last menstrual period.			
Any pain or burning on urination?			
Any incontinence or loss of urine?			
Problems with sexual functioning			
Any muscle aches, pains, backache, leg cramps?			
Any joint aches or pains? Where?			
Do you have any vision changes?			
Do you wear glasses or contacts?			
Do you smoke or use other tobacco products? What and how much?			
Do you use alcohol? How much, how often?			

Date of last visit to the eye doctor?

Date of last visit to dentist?

Foot Doctor?

Do you feel you are under stress? Mild Moderate A lot of pressure None

In the past month, have you been bothered by feeling down, depressed or hopeless? Yes No

Had little pleasure or interest in doing anything? Yes No

Please review your medication list and note any changes and/or prescriptions that need filled.

SELF CARE HISTORY

Mid-America Diabetes Associates, PA

NAME: _____ **DATE:** _____

What are your concerns you would like to discuss during today's visit?

Do you follow a meal plan for diabetes management? Please circle below:
 Calories, Points, Carbs, Exchanges, Other _____ Do you have a calorie goal? _____

LIST THE FOODS/BEVERAGES THAT YOU TYPICALLY EAT IN A DAY AND YOUR INSULIN DOSES AND TIMES IF YOU TAKE INSULIN: (MEAL EXAMPLE: 1 c. 2% milk, 1 fried chicken thigh, 1/2 cup mashed potatoes)

First Meal: Usual Time _____ Insulin Dose(s): _____ Insulin type: _____
 Food/Beverages: _____

Second Meal: Usual Time _____ Insulin Dose(s): _____ Insulin type: _____
 Food/Beverages: _____

Third Meal: Usual Time _____ Insulin Dose(s): _____ Insulin type: _____
 Food/Beverages: _____

Do you eat snacks? Yes No If so, what time(s) of day? _____
 Typical Food/Beverages: _____
 If you are on insulin, do you take insulin with snacks? Yes No If Yes, what dose? _____

Morning basal insulin (i.e. lantus/levemir/ 70/30) insulin type _____ dose _____ time _____
 Evening or Bedtime insulin type : _____ dose: _____ usual time: _____

Pump Basal Rates: _____

Name of Insulin Pump: _____

If you are on insulin or insulin pump, what sites do you use? Circle: arms legs abdomen back hips other _____

Do you have lumps or dips where you give shots? Yes No Do your shots burn? Yes No Bleed? Yes No

Brand of Glucose Meter: _____ Do you have control solution? _____

Enter your ACTUAL average blood glucose from your downloaded meter or record book:
 (Our medical assistant will be happy to assist you if needed)

Breakfast		Lunch		Supper		Bed-time	Other
Before	After	Before	After	Before	After		

Reaction/Blood Sugars below 60 (Number past month) _____

Any resulting in unconsciousness: Yes No How many? _____

How was the severe low treated? _____

Do you participate in physical activity? Yes No What and how often? _____