WELCOME ASSESSMENT: NEW PATIENT - ADULT DIABETES

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Other (specify): _____

Date of Diagnosis (can be approximate): _____

Allergies (including medication): _____

_____

Guardian/Representative Name(s): _____

General Health History

1. List any surgeries or procedures planned in the next 3 months:

   _____

2. Reason for being in/at hospital, Emergency Department, Urgent Care in last 30 days:

   _____

	Yes	No	N/A	
3.	☐	☐	☐	Do you have a primary care provider? [Name: _____ Last visit: _____]
4.	☐	☐	☐	Have you had a foot exam in the past year? [Last visit: _____]
5.	☐	☐	☐	Do you check your feet daily?
6.	☐	☐	☐	Do you see a podiatrist? [Last visit: _____]
7.	☐	☐	☐	Do you see a dentist? [Last visit: _____]
8.	☐	☐	☐	Are you planning to get pregnant?

9. Date of last dilated eye exam: _____

Diabetes Health History

1. How many times have you been in the hospital/emergency room for **low blood sugar?** _____

2. How many times have you been in the hospital/emergency room for **high blood sugar?**_____

	Yes	No	N/A	
3.	☐	☐	☐	Have you ever had diabetic ketoacidosis? [Date: _____]
4.	☐	☐	☐	Do you ever test for ketones?
5.	☐	☐	☐	Do you have concerns regarding low blood sugar?
6.	☐	☐	☐	Do you have glucagon at home?
7.	☐	☐	☐	Do you have questions regarding managing diabetes when sick?
8.	☐	☐	☐	Do you have questions regarding emergency preparedness concerning diabetes?
9.	☐	☐	☐	Do you wear or carry a medical alert/medical ID for diabetes? If yes, type: _____

central peninsula diabetes center

209 West Katmai Avenue in Soldotna, AK 99669
Phone: 907-714-4726 Fax: 907-416-7682 * www.cpgh.org

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WELCOME ASSESSMENT: ADULT DIABETES (cont'd…)

Glucose Monitoring

1. Do you have a blood glucose meter? ☐ Yes ☐ No Brand/type? _____
2. Have you used a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No ☐ Currently Brand/type? _____

General Diabetes Education

1. Have you received education on the following topics **in the past?:** (Select all that apply)

☐ What causes diabetes
☐ Education about your diet
☐ Exercise and diabetes
☐ How different kinds of diabetes medicine works
☐ How to check blood sugar
☐ Preventing and treating lows
☐ Complications of diabetes
☐ Self-care and emotional health
☐ Setting goals for care

2. Please list any other topics or concerns that you would like to discuss with the Diabetes Center staff during your visit:

_____

_____

_____

The information provided on this form is true and accurate to the best of my knowledge.

Patient/Representative (Printed named): _____

Patient/Representative (Signature): _____

Date: _____ Time: _____ Relation to Patient: _____

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