# WELCOME ASSESSMENT: PEDIATRIC DIABETES

Patient Name: _____ Today's Date: _____

Date of Birth: _____

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

Date of Diagnosis: _____

Allergies (including medicines): _____

_____

Parent/Guardian/Representative Name(s): _____

## Communicating Patient Education

1. How does the child learn best? ☐ Written materials ☐ Verbal Discussion ☐ Video ☐ _____
2. Does the child have difficulty with: (Select all that apply)
   ☐ Listening ☐ Reading ☐ Writing ☐ Hearing ☐ Seeing ☐ Understanding
3. How do you learn best? ☐ Written materials ☐ Verbal Discussion ☐ Video ☐ _____
4. Do you have difficulty with: (Select all that apply)
   ☐ Listening ☐ Reading ☐ Writing ☐ Hearing ☐ Seeing ☐ Understanding

## General Health History

1. List any surgeries or procedures planned in the next 3 months: _____
2. Does the child have any of the following due to diabetes: (Select all that apply) ☐ **None**
   ☐ Eye Issues ☐ Nerve Pain ☐ Kidney Issues ☐ High Blood Pressure ☐ High Cholesterol
   ☐ Heart Disease ☐ Thyroid Disease ☐ Foot Issues ☐ Frequent Infections ☐ Dental Issues
   ☐ Difficulty coping
3. Which tests/procedures has the child had in the last 12 months?
   ☐ Dilated eye exam ☐ Urine test for protein ☐ Foot exam - [☐ self or ☐ healthcare provider]
   ☐ Dental exam ☐ Blood pressure ☐ Cholesterol ☐ A1C
4. Name of providers the child sees:
   Endocrinologist name: _____ Last visit date: _____
   Primary Care Provider name: _____ Last visit date: _____
   Other specialists: _____ Last visit date: _____
5. Does the child use tobacco products?
   ☐ No (Quit Date: _____) ☐ Yes: Type/Amount: _____
6. Does the child use any substances including vaping and marijuana?
   ☐ No (Quit Date: _____) ☐ Yes: Type/Amount: _____
7. Does the child drink alcohol?
   ☐ No (Quit Date: _____) ☐ Yes: Type/Amount: _____

## Diabetes Health History

1. Where was the child diagnosed? City: _____ State: _____
2. Did the child visit the emergency room during the diagnosis period? ☐ Yes ☐ No
3. Was the child admitted to a hospital at diagnosis? ☐ Yes ☐ No
   a. Name of hospital: _____ City: _____ State: _____
4. Was the child in diabetic ketoacidosis (DKA) at diagnosis? ☐ Yes ☐ No ☐ I don't know
5. How many times has the child been hospitalized for **DKA** (not including diagnosis)? _____ **(continued…)**

central peninsula diabetes center

209 West Katmai Avenue in Soldotna, AK 99669
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Patient Label

## ASSESSMENT: PEDIATRIC DIABETES (cont'd…)

### Diabetes Health History

**(cont'd)…**

6. How many times has the child been in the hospital or emergency room for **low blood sugar?** _____
7. Has the child been **hospitalized for any other reason or had surgery?** ☐ Yes ☐ No
   a. If yes, describe: _____
   _____
   _____
8. Does the child or any family member have thyroid or celiac disease? ☐ Yes ☐ No
   (If yes, please list): _____
9. Are there other health concerns not already listed? ☐ Yes ☐ No
   (If yes, please list): _____

### Glucose Monitoring

1. Does the child have a blood glucose meter? ☐ Yes ☐ No
2. Does the child use a Continuous Glucose Monitor (CGM)? ☐ Yes ☐ No Type/Brand: _____

### Medications

1. Current diabetes medications: _____
   ☐ Insulin Pump ☐ Insulin Injections ☐ Oral ☐ Other_____
   - If using Insulin Pump:
     Brand: _____
     - How many years has the child been using an insulin pump? ☐ Less than 1 ☐ 1 - 2 ☐ 3 or more
     - Does the child's pump work with a CGM(integrated/automated)? ☐ Yes ☐ No ☐ Not sure
     - Does the child have an off-pump insulin injection plan? ☐ No ☐ Not Sure ☐ Yes, it is:
       _____
     - Does the child have a DKA prevention plan? ☐ No ☐ Not Sure ☐ Yes, it is:
       _____
2. In a typical week, how many times does the child miss taking their diabetes medications? _____
3. Do you have concerns regarding high or low blood sugar? ☐ Yes - [☐ Low ☐ High] ☐ No
4. Do you have glucagon at home? ☐ Yes ☐ No
5. Has the child ever received a glucagon injection or nasal spray? ☐ Yes ☐ No If yes, when? _____

### Eating Patterns

1. Do you or the child: (Select all that apply)
   ☐ Count carbs ☐ Read Food labels ☐ Use carb counting apps
   - If carb counting or diabetes apps are used, which one(s): _____
   _____
2. Have you met with a dietitian concerning diabetes before? ☐ Yes ☐ No ☐ Not sure **(continued…)**

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### Concerns and Sick Days

1. Does the child wear or carry a medical alert/medical ID for diabetes?

   ☐ No ☐ Yes, type: _____

2. Number of days in the past year the child missed school due to diabetes: _____
3. Number of days in the past year child missed sports/other activities due to diabetes: _____
4. Do you check for ketones? _____ ☐ Urine ☐ Blood If yes, when? _____
5. Child's school: _____ Grade Level: _____

   Sports/Activities:_____

### 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 work
      ☐ Insulin injection by syringe
      ☐ Insulin injection by pen
      ☐ Insulin pumps
   ☐ How to check blood sugar
      ☐ Continuous glucose monitoring
   ☐ Preventing and treating lows
   ☐ Preventing and treating highs
      ☐ How to check ketones
      ☐ Preventing DKA
   ☐ 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 Parent/Guardian/Representative (Printed named): _____

Patient Parent/Guardian/Representative (Signature): _____

Date: _____ Time: _____ Relation to Patient: _____

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