



Diabetes Medical History Form

Name _____ Phone _____
 Email _____ Date _____

 For office use only: Staff Initial _____
 Participant recommended for group class? Yes No Date _____

General Information

What would you like to learn in these classes? _____

Do you feel comfortable learning in a group class?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there anyone who will help you in your diabetes care? If yes, who? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

What is the main language spoken in your home? _____

How do you rate your ability to read English? Very Good Good Not Good

Do you understand English well enough to be in the class without an interpreter?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have hearing or visual problems that will affect your learning in a group class?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you follow any cultural or religious food restrictions or practices? If yes, _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Health Beliefs

How much of the managing of diabetes do you feel is in your hands?

- Little of it Some of it Most of it

In your doctor's hands?

- Little of it Some of it Most of it

Medication

If you take insulin:

Do you use a: syringe insulin pen insulin pump

What injection sites are used? _____

Where do you keep your insulin? _____



Do you take diabetes medication? If yes, please list the amount and when you take it.

Name and Dose	When is your medication taken?

Do you take any over the counter medications or supplements?

Name and Dose	When do you take it?

Monitoring

What is your daily blood sugar normal range? _____

Do you have a prescription for testing supplies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Hypoglycemia

Have you ever had a low blood sugar reaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, How did you treat it? _____ How often has this occurred? _____	
Do you carry a source of sugar with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had to be given glucagon?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Diabetes Complications

Do you have any of the following medical problems?

Check if it applies			Check if it applies	
	Eye problems			Heart problems
	Kidney problems			Numbness/pain
	Sexual problems			Dental problems
	High cholesterol			Depression
	High blood pressure			

Please explain?



In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Medical History

When was your last: physical _____ eye exam _____
 dental exam _____ foot exam _____

What was your last A1c? _____ date _____ Don't Know

Have you ever been hospitalized with diabetes? If yes, how many times? _____ When was the last time? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in the emergency department because of your diabetes? If yes, how many times? _____ When was the last time? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you wear a medical identification bracelet or necklace?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had a Pneumonia vaccination?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received a Flu shot within the year?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any other information that you feel would be important for the AAHP to know.
