CENTRAL OHIO™
PRIMARY CARE
Innovative Diabetes
Management Program

614-447-9495, ext. 1

You are scheduled to attend a series of four diabetes education classes. If you are not able to attend the class series, we ask that you cancel your appointment at least 48 working hours before the class series begins. Because of the demand for classes we will charge $25 to those who fail to notify us that they will be unable to attend the series.

OSU insurance plans pay for diabetes education and offers additional benefits for employees with diabetes.

Standard Medicare covers 80% of the cost leaving a balance for the series of less than $60.00 after your yearly deductible has been met. If you have a secondary insurance we will file with them also. Managed Medicare plans pay 100% of the cost.

Glucose testing:

During the four weeks that you are attending classes we will ask you to check your blood sugar before and after meals. (You should still attend classes even if you choose not to do this.) You will need approximately 150 testing strips and lancets (the little needles). Ask your doctor to give you a prescription that says you will be testing seven times a day. If you do not already have a glucose meter, we will give you one and teach you how to use it. Wait until you have the meter to contact your doctor.

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Name: _____ **Date:** _____

Doctor: _____ **Date of birth:** _____

Personal History

Do you live alone? ____Yes ____ No

How long have you had diabetes or high blood sugar? _____

Does anyone else in your family have diabetes? ____ Yes ____ No If so, who? _____

Any diabetes education in the past? ____Yes ____ No When? _____

Where? _____ Educator _____

Do you feel your diabetes is in good control? ____Yes ____ No

If no, where do you think you need help? _____

Health History

Are you being treated for any of the following?

__ High Blood Pressure Medicine _____

__ Heart Disease Medicine _____

__ Eye Disease Medicine _____

__ Allergies Medicine _____

__ High cholesterol/triglycerides Medicine _____

__ Depression Medicine _____

__ Other problems Medicine _____

Do you smoke? ____Yes ____ No If yes, how much per day? ____ week? ____

Do you drink alcohol? ____Yes ____ No If yes, how many per week? ____

When was your last complete physical? _____ By whom? _____

When was your last eye exam? _____ By whom? _____

When was your last dental exam? _____ By whom? _____

Have you been to an emergency room, urgent care, or hospital for any diabetes problems in the last year?

____Yes ____ No When? _____ Why? _____

Diabetes Medicines

Do you take an oral agent (diabetes pill)? ____ Yes ____ No

Name of oral agent(s) _____

Dose _____ Time(s) of day _____

How long have you been taking diabetes medicine? _____

Do you take insulin? ____ Yes ____ No

Type of insulin? ____ **R**(regular) ____**N**(NPH)**Humalog/Novolog/Apidra 70/30 75/25 Lantus/Levemir**

How much do you take? (List type and amount of each insulin)

Morning dose _____

Noon dose _____

Dinner/Supper dose _____

Bedtime dose _____

Where do you inject insulin? ____ Abdomen ____ Arms ____ Leg ____ Other _____

Do you have any itching, swelling, redness, or hardness at sites? ____ Yes ____ No

Do you adjust the amount of insulin you take? ____ Yes ____ No

How many times do you skip a dose or take it more than an hour late? _____

Where do you keep the insulin you use now? _____

Are you on Byetta/Victoza/Symlin? ____ Yes ____ No Current dose _____ mcg times of day _____

Monitoring

Do you check your blood sugar at home? ____ Yes ____ No

How often do you check your blood sugar? Times per day _____ Times per week _____

What meter do you use? _____

What is your average blood sugar in the morning before eating? _____

Do you know your hemoglobin A1c level? ____ Yes ____ No ____ Don't know what this is

Do you check your urine for ketones? ____ Yes ____ No ____ Don't know what this is

Hypoglycemia

Do you ever have low blood sugar reactions? ____ Yes ____ No ____ Don't know

How may times per week? _____ Per month? _____

What do you eat or drink for a low blood sugar? _____

Do you carry this with you? ____ Yes ____ No

Do you wear a medical identification tag or carry a card? ____ Yes ____ No

Have you ever passed out from a low blood sugar? ____ Yes ____ No When? _____

If you take insulin, do you have a glucagon kit? ____ Yes ____ No

Exercise

How often do you exercise per week? _____

What kind of exercise(s) do you do? _____

How long do you exercise each time? _____

Do you get out of breath or sweaty during exercise? ____ Yes ____ No

Do you get pains in your legs while walking or during exercise? ____ Yes ____ No

Nutrition Management

Do you follow any specific nutrition or meal plan? ____ Yes ____ No

If yes, what is it? _____

Do you follow any food restrictions? (check any that apply)

____ Low sodium ____ High potassium ____ Low potassium ____ Low fat ____ Low protein

Other _____

How may meals do you usually eat per day? _____

Do you eat planned snacks? ____ Yes ____ No

If yes, what and when? _____

How many times a week do you skip a meal or snack? Meal _____ Snacks _____

Do you want to lose weight ____ Yes ____ No

Do you have any food allergies? ____ Yes ____ No

If yes, what? _____

Do you take any vitamins or herbal supplements? ____ Yes ____ No

If yes, what? _____

How many meals do you eat away from home in a usual week? _____

Do you ever binge? (eat uncontrollably)? ____ Yes ____ No

If yes, how often? _____

How do mood changes or stress affect your eating? _____

Foot Care

How often do you check your feet? ____ Rarely/Never ____ Occasionally ____ Often ____ Daily

Do you take your shoes and socks off for a foot exam each time you visit the doctor? ____ Yes ____ No

Do you see a podiatrist? ____ Yes ____ No

If yes, how often? _____

Emotional Aspects of Diabetes

Have you ever been diagnosed or treated for depression? ____ Yes ____ No

Diabetes affects the whole person and can give rise to feelings of anger, sadness, or being overwhelmed. It is important to recognize and deal with these feelings when they exist. Otherwise, overall diabetes care and personal satisfaction are affected. Please answer Yes or No to the following questions.

In the last two weeks

Have you been feeling sad . . . depressed?	____ Yes ____ No
Are you getting less pleasure from your job, sports, hobbies?	____ Yes ____ No
Do you often feel tired?	____ Yes ____ No
Do you have trouble sleeping too much?	____ Yes ____ No
Have you been gaining or losing weight?	____ Yes ____ No
Do you often feel down on yourself, that everything is your fault?	____ Yes ____ No
Do you have trouble making decisions or concentrating on your work?	____ Yes ____ No
Do you often feel agitated or like you can barely move?	____ Yes ____ No
Do you ever feel that your life isn't worth living?	____ Yes ____ No

Emotional Aspects of Diabetes (continued)

Circle any words that describe how you currently feel about your diabetes and how it affects you:

Overwhelmed Hopeful Out of control Positive Hassled Burdened
Encouraged Alone Confident Successful Angry Confused

What is your greatest fear about having diabetes? _____
_____
_____

Please list the three things that you most want to learn and/or change about your diabetes and how you take care of it:

1. _____

2. _____

3. _____

_____ _____
Patient's signature **Date**

_____ _____
Educator's signature **Date**