Baptist HEALTH

Center For Diabetes
Health History

Name:_____ Sex: ❑ M ❑ F Date of Birth: ____/____/____
MM DD YY

Home/Cell Phone: _____ Work Phone: _____ May we call you at work? ❑ Y ❑ N

Email Address:_____

Highest grade completed: _____ Preferred Language: _____

Occupation:_____ Employer:_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Do you have someone who provides emotional support? ❑ Y ❑N If Yes, Relationship: _____

Do you feel that you have an unusual amount of stress in your life? ❑ Y ❑ N If yes, what is/are the major sourcesof stress in your life? ❑ work ❑family ❑illness ❑financial ❑other:

How do you cope with your stress?_____

Height:_____ Weight Today:_____ Weight 1 year ago:_____ Goal Weight:_____

Year diagnosed with diabetes:_____ Or ❑ Recently diagnosed ❑ Type1 diabetes ❑ Type 2 diabetes

Family History of Diabetes ❑ Yes ❑ No History of Gestational Diabetes: ❑ Yes ❑ No

Please list <u>diabetes medication</u> (insulin and/or pills)below: ❑ I am not on any medicine for diabetes

Insulin or pill	Dose before/after breakfast	Dose before/after lunch	Dose before/after dinner	Dose at bedtime

What other medication do you take?_____

_____

Drug allergies?_____

How often do you test your blood sugar at home?_____times per ❑ Day ❑ Week ❑ Month ❑ I do not test

Name of meter you use:_____ Year purchased:_____

Do you have problems with blood sugars going too low? ❑ Y ❑ N

How often?_____ Cause:_____

How do you treat low blood sugars?_____

Do you wear diabetic ID? ❑ Y ❑ N

My health is generally ❑ excellent ❑ good ❑ fair ❑ poor

Explain:_____