Baptist Health

Center For Diabetes
Health History

EYES: ❑ Blurred vision ❑ Laser treatment Year of last dilated eye exam _____

KIDNEYS ❑ Infections ❑ Protein in urine ❑ Diabetic kidney disease

FEET/LEGS ❑ Ulcers ❑ Thick toe nails ❑ Amputation ❑ Ingrown toenails
❑ Calluses/corns ❑ Tingling/numbness ❑ Pain on walking
Do you inspect your feet daily? ❑Y ❑N

CARDIOVASCULAR ❑ Heart failure ❑ Angina ❑ Heart attack ❑ High Cholesterol
❑ High blood pressure ❑ Stroke ❑ Heart surgery

GASTROINTESTINAL ❑ Frequent nausea and/or vomiting ❑ Frequent diarrhea or constipation ❑ GERD

SPECIAL NEEDS ❑ Hearing ❑ Speech ❑ Vision ❑ Transportation
❑ Mobility ❑ Reading ❑ Writing

OTHER ❑ Arthritis ❑ Ketoacidosis ❑ Depression
❑ Thyroid disease ❑ Change in sexual function ❑ Frequent infections
❑ Other _____

Do you exercise? ❑Y ❑N Type of exercise you do: _____

How often?_____ times per ❑Day ❑ Week ❑ Month For how long per session? _____

How many times do you eat a day(including meals and snacks)? _____

What beverages do you drink daily?_____

Do you drink alcohol? ❑Y ❑N How many drinks per week?_____

Do you use tobacco? ❑Y ❑N What form? _____ How much? _____

Cultural or religious customs affecting your food choices or diabetes care? _____

How do you feel about having diabetes?_____

Please list 2 things that you hope to achieve/learn by participating in this program:
1. _____ 2. _____

PLEASE DO NOT WRITE IN THIS BOX – OFFICE USE ONLY Weight:_____ Date: _____

FBS:_____ Date: _____ CHOL:_____ Date: _____ TRIG:_____ Date: _____

HgbA1C: _____ Date: _____ LDL:_____ Date: _____ Other abnormal labs: _____

BP:_____ Date: _____ HDL:_____ Date: _____ _____

COMMENTS: _____

_____

_____

RN/RD Name (Print): _____

RN/RD Signature:_____ Date: _____Time: _____