St. Francis Hospital
DIABETES TREATMENT

Refresher Class Assessment

(Please complete front and back of this form)

Demographic information: Today's Date:_____

Name:_____ Preferred Name:_____ Date of birth:_____

Primary Language: ☐English ☐Spanish ☐French ☐Other_____

Race/Ethnicity: ☐Black ☐African American ☐Hispanic ☐Middle Eastern ☐Asian/Pacific Islander ☐American Indian or Alaskan Native ☐White/Caucasian ☐Other:_____

Please list cultural or religious beliefs that may impact your care:_____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Do you work? ☐Yes ☐No What do you do for work?_____ Work Hours?_____

Medical information:

Height _____ Weight _____

Tobacco use? ☐Yes ☐No What type of tobacco product?_____ How much per day?_____

Alcohol use? ☐Yes ☐No How many alcoholic beverages per week?_____

Other medical conditions- Circle all that apply:

High blood pressure	Heart problems	Dental problems
High cholesterol	Kidney problems	Yeast Infections
Sleep Apnea	Nerve Problems	Erectile Dysfunction
Gastroparesis	Circulation problems	Congestive Heart Failure

Medical conditions not mentioned above: _____

Any allergies to food or medications? _____

Over the past two weeks, how often have you been bothered by any of the following problems? Please choose an appropriate response for each item:

Little interest or pleasure in doing things

☐Not at all ☐Several days ☐More than ½ the days ☐Nearly every day

Feeling down, depressed, or hopeless

☐Not at all ☐Several days ☐More than ½ the days ☐Nearly every day

Feeling bad about yourself or that you are a failure, or have let yourself or your family down

☐Not at all ☐Several days ☐More than ½ the days ☐Nearly every day

Thoughts that you would be better off dead or hurting yourself in some way

☐Not at all ☐Several days ☐More than ½ the days ☐Nearly every day

Diabetes information:

What type of Diabetes do you have? ☐Type 2 ☐Type 1 ☐Other:_____

Who is your main support person?_____

How would you rate your overall health: ☐Excellent ☐Good ☐Fair ☐Poor

Current diet/meal plan:_____

Have you made any recent changes to your diet? What changes? _____

_____

Do you tend to skip meals? □Yes □No If yes, which do you skip: □Breakfast □Lunch □Dinner
Please list all of the beverages you usually drink:_____

_____

How many times a week do you dine out? □≥8 times □5-7 times □3-5 times □2-3 times □1-2 times
What is your biggest challenge when it comes to food?_____
Do you exercise? How often, and what type? _____
What (if any) challenges do you have concerning physical activity:_____
What is the name of your blood sugar machine? _____
How often do you check blood sugar? 2-3 times/day / 1 time/day / 2-3 times/week / Never
When do you check? □First thing in the morning □Before meals □After meals □Before bed
In the last 7 days, what was your lowest and highest blood sugar? Lowest:_____ Highest:_____
What is the hardest part about having diabetes? _____

Please check all that apply and list doses and how often you take the medication.

- **Diabetes Pills**: (Metformin, Glipizide, Glimepiride, Januvia, Janumet, Farxiga, Invokana, Jardiance, Actos, Kombiglyze, Xigduo, Other)

  _____

□

- **Non-Insulin Injection:** (Byetta/Bydureon/Victoza/Symlin/Trulicity)

  _____

- **Insulin Injection**: (Lyumjev, Lantus, Levemir, Novolog, Humalog, 70/30 Mix, NPH, Other)

  _____

  *Method of administration: (Circle) □ Pen □ Pump □Syringe

- **Inhaled insulin** (Afrezza):

  _____

Learning needs/goals:
What is the last grade you completed in school? _____
Do you have any learning disabilities (such as dyslexia) or problems with vision, hearing, or reading? Please explain: _____

How do you prefer to learn? □Listening □Reading □Demonstration □Doing □Group Session □No learning preference □Other_____

Diabetes Treatment Center Staff Only: **signature indicates completion of face-to-face assessment**

Reviewer's signature/title and date: _____

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