Yuma County Diabetes Consortium
Intake and Assessment Form

Date:___/___/___ Person filling out form:_____

Last Name:_____ First name:_____

DOB:___/___/___ Age:_____ Gender: M F

Address:_____ City/Zip:_____

Phone:_____ (W)_____

Emergency Contact:_____ Relation:_____ Phone:_____

Marital Status: M S D W Do you live alone? Yes No: With whom?_____

Ethnicity: Asian Hispanic African American Native American Anglo Other_____

Education level: <HS HS Some college ≥BA

Which language do you prefer to speak?_____ Read?_____

Insurance:_____ Physician:_____

Aware of program by:_____ Referred by:_____

Personal and Medical History:

1) When were you diagnosed with diabetes? ___/___ Years with diabetes ____ Prior diabetes education? Y N

2) Have any other family members been diagnosed with diabetes? Y N Who? _____

3) How can diabetes affect your health? _____

4) Does your family understand how diabetes can affect your health? Y N

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

6) What do you feel caused your diabetes?_____

7) What do you want this program to do for you?_____

8) WOMEN: Number of pregnancies? ___ Diabetes during pregnancy? Y N Any babies over 9 lbs? Y N

9) Do you have, or have you had:

__ depression	__high blood pressure	__heart problems	__sexual problems
__kidney/bladder infections	__urine microalbumin	__asthma/lung problems	__thyroid problems
__yeast infections	__skin infections	__liver problems	__vision problems
__frequent constipation	__numbness, burning, or pain in feet	__problems using hands or walking	

10) Do you use any alternative ways of treating your diabetes? (herbs, curandero/a etc.)

_____

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11) Do you smoke? Never Quit, when ___/___ Yes: Less than pack/day__ More than pack/day__

12) Do you drink alcohol? No Yes: 1-2/week__ 1/day__ More than 1/day__

Is alcohol a problem? No Yes

13) Do you exercise? No Yes: What kind of exercise:_____ How many times a week?____

How hard do you work when you exercise? Hard__ Somewhat hard__ Easy__

Do any family members exercise with you? No Yes: Who?

_____

14) Do you check your blood sugar at home? No Yes: Which glucometer do you use?_____

15) Is your diet different from your family's? No Yes: How:_____

Does your family help you follow your diet? No Yes

16) Do you check your feet? No Yes: How often: Daily__ Weekly__ Monthly__

17) Have you been in the hospital in the last year because of your DIABETES? No Yes

Why were you admitted? Sugar too high__ Sugar too low__ Infection__ Other_____

18) How many times in the last year have you seen your doctor for your DIABETES? ____

At any of these visits did the doctor examine your feet? No Yes Check urine? No Yes

19) Have you ever had a dilated pupil eye examination? No Yes: When(year)?_____

20) Do you know what a Hemoglobin A1C blood test is? No Yes Ever had one? No Yes: When:___/___

What medications do you takes? (List DIABETES medications first.)

MEDICATION	DOSE	TIMES		OTC MEDICATIONS	OTHER TREATMENTS

Are you allergic to any medication? N Y: What?_____

Reaction?_____

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