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.

Standard Medicare and Managed Medicare plans pay for diabetes education.

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 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). If you are already using a glucose meter, as your doctor to give you a prescription that says you will be testing seven times a day. If you do not have a glucose meter we will get you set up with one and teach you how to use it. You can contact your doctor after we've given you the meter for a prescription for additional supplies.

Pre-Diabetes and Diabetes Class Assessment
Please complete the best you can and bring to the 1st class. If something does not apply to you, please leave it blank.

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 pre-diabetes/diabetes? Yes No
Who?_____

Any diabetes education in the past? Yes No When?_____
Where?_____Educator_____

Do you feel your pre-diabetes/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? Please circle all that apply.

High Blood Pressure Heart Disease Eye disease* Allergies High Cholesterol

High Triglycerides Kidney Disease Neuropathy Hearing loss* Depression

*If you have hearing or vision loss how can we best help you in classes? _____
_____

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 dilated eye exam? _____By whom?_____
When was your last dental exam? _____By whom?_____
Has your doctor checked your feet in the past year? Yes_____ No_____

Have you been to an emergency room, urgent care, or hospital for any diabetes problems in the last year? Yes No
When?_____Why?_____

How often does someone help you read medical forms?
Always Often Sometimes Never

Pre-Diabetes/Diabetes Medicines

Do you take any pills for pre-diabetes/diabetes? Yes No

Name of your diabetes pills, dose and time of day taken:

_____

_____

How long have you been taking this medicine? _____

Do you take insulin? Yes No

Type of insulin? (please circle all that apply): **R**(regular) **N**(NPH) **Humalog Novolog Apidra Fiasp 70/30 75/25 Lantus Levemir Toujeo Tresiba Basaglar Other**

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?_____

Do you take any other diabetes meds that you inject? If yes, circle what applies:

Bydureon Trulicity Victoza Symlin Ozempic Other

When do you take it? _____

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?_____

Does your insurance pay for your test strips? Yes No

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

Hypoglycemia

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

How many times per week?_____per month?_____

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

Do you carry this with you? Yes No

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

Do you wear a medical identification bracelet or necklace? Yes No

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 (including cultural preferences)? Yes No
If yes what is it?_____
Do you follow any food restrictions? (circle any that apply)
Low sodium High potassium Low potassium Low fat Low protein
Other_____
How many meals do you usually eat per day?_____
Do you eat planned snacks? 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?_____
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 see a podiatrist? Yes No
If yes, how often?_____

Emotional Aspects*: Please check your response to the following statements.

	Agree	Somewhat Agree	Somewhat Disagree	Disagree
I feel good about my general health				
I feel good about how I manage my pre-diabetes/diabetes				
I feel good about how my doctor is helping with my pre-diabetes/diabetes management				
My energy level is good				
My pre-diabetes/diabetes does not interfere much with other aspects of my life				
My stress level is manageable				
I have some control over whether I get complications or not				
Making changes in my life to care for my pre-diabetes/diabetes is important				
I feel supported in my efforts to manage my pre-diabetes/diabetes				
I feel my life is worth living				

*Adapted from Diabetes Distress Scale, Behavioral Diabetes Institute

Emotional Aspects of Pre-Diabetes/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 concerns you most about having pre-diabetes/diabetes? (circle all that apply)

Change to food choices Having to take medications/shots

Complications Family response Cost of treatment Checking blood sugar

Change to lifestyle Side effects of meds Losing control of diabetes

Is there anything else you would like us to know about your diabetes or pre-diabetes?

_____
_____
_____

_____
Patient's signature **Date**

_____
Educator's signature **Date**
☐ **Educator reviewed**