PATIENT HEALTH SURVEY

Thank you for completing this thorough questionnaire. Diabetes involves many aspects of life. This information helps us to help you. We look forward to being a part of your diabetes team.

General Information

Name: ________________________________ **Date**: ______________
Birth date: _________ Age: ____ Gender: ______
Best phone number_______________ Best time to call_______ OK to leave messages?☐Yes ☐No
What is your preferred language? _______________spoken _______________written
Primary Care Doctor: ______________________ Diabetes Doctor: _________________________
If you would like to be added to a confidential mailing list to receive diabetes-related updates, please CLEARLY write your **email** address here:

Diabetes History

Date diagnosed:______Blood glucose (sugar) on diagnosis:____ Recent A1C/date (if known):_____

What type of diabetes do you have?
☐ Don't know ☐ Type 2 ☐ Type 1 (Do you wear a pump? ☐ Yes ☐ No) ☐ Other
For women, did you have gestational diabetes or a baby weighing more than 9 pounds? ☐Yes ☐No

Any family members with diabetes? ☐ Yes ☐ No If yes, who _________________________
How do you feel about having diabetes?

Have you ever had diabetes education? ☐ Yes ☐ No When? ____________ Where? __________

How would you rate your understanding of diabetes? ☐ Good ☐ Fair ☐ Poor

Does anybody help you take care of your diabetes? ☐ No ☐ Yes. Who?___________________

What do you want to learn? ☐ Healthy eating ☐ Exercise guidelines ☐ Monitoring glucose
☐Medication info ☐ Dealing with stress ☐Problem solving ☐Reducing complication risk
☐ Other:

Medical History

How would you rate your general health? ☐ Excellent ☐Good ☐Fair ☐Poor

What other conditions or problems do you have?
☐ blood pressure ☐ cholesterol ☐ heart ☐ eye ☐ thyroid ☐current/recent infection
☐ kidney ☐ sexual ☐ gastrointestinal ☐ nerve (neuropathy) ☐ depression
☐ Other Explain any of these: ____
Major operations/recent hospitalizations:____

Last eye exam? _____________ Last foot exam? ______________ Last medical exam?_______
Last dental checkup? __________ Last flu shot? ______________ Last pneumonia shot?________

The Center for Diabetes Services
3801 Sacramento Street, 7th Floor
San Francisco, California 94118
Ph: (415)600-0506 Fax: (415)600-6279

PATIENT IDENTIFICATION

California Pacific Medical Center

A Sutter Health Affiliate

Nutrition

What is your current weight? __________Height?_________

What is your goal weight?_____________

Has your weight changed in the past year? ☐ Yes ☐ No _____________ pounds (☐gained ☐lost)

Do you have a history of an eating disorder? ☐ Yes ☐ No (describe) _________________________

Who cooks? ______________________________Who shops? _______________________________

How often do you eat out and where? ____

What special food plan or diet do you follow (including any cultural/religious diet restrictions, if any)? Type ____

What changes have you made in your diet recently, if any ____________________________________

Do you count carbohydrates? ☐ Yes ☐ No

List any food allergies or intolerances ____

Diet History (what foods do you usually eat). **List types and amounts.**		
Breakfast	Lunch	Dinner
Snacks:		

Exercise

Have you been advised to limit exercise? ☐ Yes ☐ No (describe) __________________________

Do you exercise on a regular basis? ☐ Yes ☐ No Type _________________________________

How many times a week do you exercise? ______________ For how long? _____________ minutes

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Pain Assessment

Are you having any pain now? ☐ Yes ☐ No (skip this section)
Where is the pain? ________________ Describe ______________ ____________
Are you under the doctor's care for pain? ☐ Yes ☐ No

Current Level of Pain: (circle the number that reflects the intensity)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
None		Mild		Moderate		Severe		Very Severe		Worst Possible
Annoying		Uncomfortable		Distressing		Horrible		Excruciating		Agonizing

What is your goal? ☐ comfortable ☐ increase function ☐able to sleep ☐ reduce intensity
What do you do to manage the pain?

Monitoring

Do you test your blood glucose (sugar)? ☐ Yes. My type of meter is_______________________
☐No (skip to "Lows" below)

What do you consider an acceptable blood glucose reading? ______________________________
How often do you test?__________________What time(s) of the day?______________________
Usual blood glucose before meals: _________ Two hours after meals:_________

Lows

Have you ever had low blood glucose? ☐ Never (skip to "Highs" below) ☐When?_____________

Can you feel when your glucose is too low? ☐No ☐Yes, my symptoms:_____________________

How do you treat low blood glucose? ____
Do you wear a medical identification bracelet or necklace? ☐ Yes ☐ No

Have you ever been unconscious from low glucose? ☐ No ☐ Yes When? ________________
Do you have a Glucagon kit at home for severe lows? ☐ No ☐ Yes. Who in your household has been taught how to use it?____

Highs

What are your current levels of high blood glucose? ☐ I don't know ☐______________________

How do you treat the highs? ____

Do you test for ketones? ☐ Yes ☐ No

Pregnancy (if applicable)

Are you currently pregnant? ☐ Yes Expected due date? ____________________ ☐ No

Are you planning to become pregnant? ☐ Yes ☐ No Birth control method? _________☐ N/A

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Risk Factors

Do you have trouble sleeping?	☐ Yes ☐ No	
Are you told you snore?	☐ Yes ☐ No	
Are you sleepy during the day?	☐ Yes ☐ No	
Smoke or exposure to cigarettes?	☐ Yes ☐ No	If yes, number of cigarettes each day__________
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much?__________________________
Do you use illicit drugs?	☐ Yes ☐ No	If yes, explain______________________________

Health Beliefs

I believe following my diet is the best thing I can do to control my diabetes.

_____Agree _____Neutral _____Disagree

I have some control over whether or not I get complications of diabetes.

_____Agree _____Neutral _____Disagree

I feel diabetes is the one of the worst things that ever happened to me.

_____Agree _____Neutral _____Disagree

I will have to or have given up many things because of my diabetes.

_____Agree _____Neutral _____Disagree

If I don't take care of myself, I believe diabetes could be a great threat to my life.

_____Agree _____Neutral _____Disagree

Social/Learning History

How do you learn best (check all that apply)?
☐ Reading ☐ Demonstration ☐ Hands on ☐ Watching TV

Do you have difficulty with: ☐Hearing ☐Speech ☐Vision ☐Mobility issues ☐Sitting for more than 2 hours ☐Concentrating Explain:____

Last Grade in School? ____________________

How would you describe the amount of stress in your life? ☐Low ☐Medium ☐High
How do you handle it? ____
Do you have any financial concerns or worries?____
Do you work? ☐ Yes ☐ No If yes, type of work? _____________ Work hours? _____________

Marital Status: ☐ Single ☐ Married ☐ Domestic partner ☐ Divorced ☐Separated ☐ Widowed
Number in Household? ________ Living situation ____
Do you have an advanced directive? ☐ Yes ☐ No

(Optional) Race/Ethnicity _____________________ (for data collection purposes only)

What else you would like us to know about you? ______________________________________
Your expectations of our diabetes program ____

Signature: ____

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