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Pediatric Endocrinology

New Patient
Diabetes Assessment

Name: ____________________________________
D.O.B.: __________________________________
Today's Date: ______________________________
Completed by: ______________________________

1. Background Information

How long have you had diabetes? ___________
Do you have: Type I? _____ Type II? _____ Not sure? _____
Is there a family history of: Type I? _____ Type II? _____ Not sure? _____
If yes, Type I? _____
Do you have other health problems? Yes _____ No _____
If yes, describe ____

Hospitalizations:

Date	Reason
__________	____
__________	____
__________	____
__________	____
__________	____

2. Insulin:

A. Brand and Type: ______________________________
Insulin Dosage:
AM _________ Lunch __________ Dinner __________ Bedtime __________

B. Insulin Pump (if used) Type: ____
Basal rates and times: ____

C. If Carb counting, what is your insulin to carb ratio: 1 unit: _____ grams of carbs
Sliding scale/correction factor (if appropriate): 1 unit drops blood sugar _____ mg/dl
Who draws up insulin? ____
Who gives insulin injections? ____
Sites used for injections:
_____ Arms _____ Stomach _____Legs _____ Buttocks
____________________ Other (Please list)
Have you noticed any changes in the skin where you give injections? Yes _____ No _____
If yes, Sunken _____ Lumps _____ Other (list) ______________________________________
Where do you store insulin? ____

Do you ever make changes in your insulin dose? Yes _____ No _____
If yes, describe ____
Do you ever forget to give insulin? Yes _____ No _____

Medications other than insulin:

Name of medication:	Reason for taking:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Allergies? Yes _____ No _____ If yes, (list) ____

3. List over-the-counter, alternative, herbal, nutritional or complementary therapies (list the name, dosage, and frequency): ____
____

4. Monitoring:

Do you do blood glucose monitoring? Yes _____ No _____
Type of equipment _________________________________
Frequency and timing of tests _________________________
What are the usual blood sugar results for a typical day?
Before breakfast __________ Before dinner __________ Before lunch _________
Before bedtime snack _________ Middle of night __________
What range would you like to see your blood sugars? _____ to _____
At what blood sugar levels do you make changes in your care? ____________________________________
Describe changes: ____
Do you test urine for ketones? Yes _____ No _____
When? ____________________ Any results positive for ketones? Yes _____ No _____
Do you keep a record of blood sugar and ketone results? Yes _____ No _____
Did you bring record with you? Yes _____ No _____

5. Hypoglycemia:

How often do you have insulin reactions? Per month __________
Please describe how you feel and what you do to treat an insulin reaction:
____
____
If you have had any severe reactions, describe: ____
____
What time of day do reactions occur? ____
What, if any, sugar source do you carry with you to treat reactions? ________________________________
Have you ever used Glucagon? Yes _____ No _____
Do you have Glucagon in your house? Yes _____ No _____
Does a family member know how to use it? Yes _____ No _____

6. Hyperglycemia/Ketoacidosis:

Is there a recent history of getting up at night to use the bathroom or bedwetting? Yes _____ No _____
If yes, how often? ____
What effect, if any, does stress have on your blood sugar? ____
Have there been any episodes of ketoacidosis (diabetic coma)? Yes _____ No _____

7. Diet:

Do you take vitamins and/or minerals? Yes _____ No _____

Food Likes	Food Dislikes
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

When was the last time your diet was reviewed by a dietitian? _____________________________________
How many calories are you allowed on your present diet? ____
How would you rate how well you follow your diet? Good _____ Fair _____ Poor _____
Who does the food shopping? ____________________ Cooking? ____________________
Do you have any financial difficulties with the food budget? Yes _____ No _____
Do you have any special concerns about the diet? Yes _____ No _____

8. Exercise:

Do you have a regular (at least 3 times per week) exercise program? Yes _____ No _____
If yes, describe ____
What type of exercise do you enjoy? ____
Do you make changes in your meal plan or insulin, based on exercise? Yes _____ No _____
If yes, describe ____

9. Education:

Where did you have initial diabetes education? ____
When was the last time you had a review of diabetes? ____
Are you a member of ADA? _____ JDRF? _____
Have you attended camp? Yes _____ No _____
List any areas where you would like more instructions: ____
____

10. Lifestyle and Daily Routine:

Name of School: ______________________________
Grade: __________
Name of School Nurse: _________________________
Phone Number of School: _______________
How many days of school per year are missed because of diabetes related problems? _____
Because of other problems? ____
Average grades: __________
Schedule (indicate times): School starts _____ Lunch _____ Gym _____ Recess _____ Ends _____
What snacks and sugar source do you keep at school? ____
Where at school is this kept? ____
Are school personnel helpful? Yes _____ No _____
Describe: ____
Do you receive any special education? ____
List any after school activities or job: ____
Are there any special weekend activities that change diabetes management (i.e. job, sports, more or less activity)? Yes _____ No _____
Do you wear a Medic Alert bracelet or necklace? Yes _____ No _____
Do you receive reimbursement for supplies? Yes _____ No _____
Do you have difficulty paying for supplies? Yes _____ No _____

What are parents' most significant concerns relating to diabetes on a daily or long-term basis? ____________

____

How do you feel about having diabetes? ____

What one thing bothers you the most about diabetes? ____________________________________

____

Are friends and family helpful regarding diabetes management? Yes _____ No _____

Describe: ____

Who lives in the household? ____

Please list family members who are involved in diabetes care: _________________________________

____

What do they do? ____

Any recent stresses to you or your family? ____

____

____

Please identify any other special concerns. Also, list anything else you want us to know about you and your family. ____

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