



# SC DHEC Adult Diabetes Needs Assessment

## GENERAL MEDICAL CONDITION

Current Medical C/O: \_\_\_\_\_  
 Type of Diabetes: \_\_\_\_\_ Duration: \_\_\_\_\_  
 Family History: Yes  No  Relation: \_\_\_\_\_  
 Other Medical Problems: \_\_\_\_\_  
 Non-DM Medications: \_\_\_\_\_

## DIETARY HABITS/PRESCRIBED DIET

Prescribed Diet Plan: \_\_\_\_\_  
 Follows Diet: Always  Usually  Sometimes  Rarely  Never   
 Prior Diet Instructions: Yes  No  When/Where: \_\_\_\_\_  
 Eating Schedule: \_\_\_\_\_

Who Prepares Diet: \_\_\_\_\_  
 Fast Food Frequency: \_\_\_\_\_  
 Alcohol: Yes  No  Consumption/Freq.: \_\_\_\_\_

## INSULIN TAKEN AT HOME

Insulin (Name/Type): \_\_\_\_\_  
 Dosage/Time: \_\_\_\_\_  
 Who Prepares Syringe: \_\_\_\_\_ Who Admin. Insulin: \_\_\_\_\_  
 Reuses Syringe: Yes  No  # Times: \_\_\_\_\_  
 Proper Procedure for Re-use: Yes  No   
 Correct Storage of insulin: Yes  No   
 Rotation of Sites (✓ Sites Used): Abd.  Legs  Hips  Arms

## ORAL HYPOGLYCEMIC AGENTS

Name/Dosage/Schedule: \_\_\_\_\_  
 \_\_\_\_\_

## MONITORING

Tests BG: Yes  No  BG Range: \_\_\_\_\_  
 Who Tests BG: \_\_\_\_\_  
 Frequency/Times: \_\_\_\_\_ Keeps Diary: Yes  No   
 Name of Meter/Strips: \_\_\_\_\_ Age of Meter: \_\_\_\_\_  
 Test for Ketones: Yes  No  Frequency/Times: \_\_\_\_\_  
 Reason for Testing: \_\_\_\_\_  
 Supplier: \_\_\_\_\_

## SUPPORT/FAMILY INVOLVEMENT

# in Household \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Support Person to Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

## ACTIVITY (Work, Sports, Exercise)

Work Schedule: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Current Exercise/Activity Plan: \_\_\_\_\_  
 ✓ Blood Glucose w/Exercise: Yes  No  When Checked: \_\_\_\_\_

## HYPERGLYCEMIC EPISODES - Symptoms

Abdominal pain: Yes  No  Hunger: Yes  No   
 Behavior changes: Yes  No  Nausea: Yes  No   
 Deep breathing: Yes  No  Vomiting: Yes  No   
 Excessive fatigue: Yes  No  Weight loss: Yes  No   
 Excessive thirst: Yes  No  Visual problems: Yes  No   
 Excessive urination: Yes  No  Recurrent infection: Yes  No

## HYPOGLYCEMIC REACTIONS

Shaking: Yes  No  Sudden Weakness: Yes  No   
 Sweating: Yes  No  Confusion: Yes  No   
 Dizziness: Yes  No  Irritability: Yes  No   
 Headache: Yes  No  Slurred Speech: Yes  No   
 Blurred Vision: Yes  No  Tremors: Yes  No   
 Nervousness: Yes  No  Seizures: Yes  No   
 Frequency: \_\_\_\_\_ Triggers: \_\_\_\_\_  
 Steps taken: \_\_\_\_\_  
 Carries Source of CHO: Yes  No  DM ID: Yes  No   
 Tests BS Before Driving: Yes  No

## HEALTH CARE UTILIZATION

MD Name: \_\_\_\_\_ Freq. of MD visits: \_\_\_\_\_  
 Recent Emergent Care: Yes  No   
 Recent Hosp. Adm. for DM: Yes  No   
 Eye Exam/Freq./Date of Last Exam: \_\_\_\_\_  
 Height: \_\_\_\_\_ Wt.: \_\_\_\_\_ Desired Wt.: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 HbA1c/Date and Frequency: \_\_\_\_\_  
 Total Cholesterol/Date: \_\_\_\_\_  
 HDL/Date: \_\_\_\_\_ LDL/Date: \_\_\_\_\_  
 Triglycerides/Date: \_\_\_\_\_  
 Smokes: Yes  No  How long? \_\_\_\_\_ Last PPD: \_\_\_\_\_  
 Last Flu Vaccine: \_\_\_\_\_ Last Pneu. Vaccine: \_\_\_\_\_

Check all that Apply:

### PROBLEM AREAS

- Retinopathy
- Nephropathy
- Neuropathy
- Heart Disease
- Peripheral Vascular Disease
- Amputations (Lower Ext.)
- Recurring Infections
- Sexual Dysfunction
- Cataracts/Glaucoma
- Hypertension
- High Cholesterol
- High Triglyceride Levels
- Dexterity Problems
- Dental

### PSYCHOSOCIAL

- Excess Weight
- Irregular Meal Times
- No Planned Exercise
- Eating Disorder
- Difficulty with Past Regimens
- Low Self Esteem
- Excess Stress
- Lack of a Support System
- Financial Concerns
- Neg. Past Experience Diabetes
- Substance Abuse
- Diabetic I.D.

## DIABETIC EDUCATION HISTORY

Prior DM Education: Pt.: Yes  No  Significant Other: Yes  No   
 When/Where: \_\_\_\_\_  
 Level of Education: 0-8 \_\_\_\_\_ H.S. \_\_\_\_\_ College: \_\_\_\_\_  
 Barriers to Learning: \_\_\_\_\_  
 Cultural/Language/Religious Characteristics: \_\_\_\_\_  
 Referrals: \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 Provider's Signature/Title \_\_\_\_\_ Date \_\_\_\_\_  
 Patient Name: \_\_\_\_\_  
 Patient ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**SC DHEC Diabetes Needs Assessment**

<b>Foot Assessment</b>	<b>Right</b>	<b>Left</b>	<b>Comments</b>
<b>Check column if applicable. Leave blank if not applicable.</b>			
Is there a foot ulcer now?	_____	_____	_____
Is there a history of foot ulcer?	_____	_____	_____
Is there an abnormal shape of the foot?	_____	_____	_____
Is there toe deformity?	_____	_____	_____
Are the toenails thick?	_____	_____	_____
Are the toenails ingrown?	_____	_____	_____
Are the toenails ridged?	_____	_____	_____
Is there callus buildup?	_____	_____	_____
Is there edema present?	_____	_____	_____
Is the skin temperature normal?	_____	_____	_____
Are brown shiny spots present?	_____	_____	_____
Are peripheral pulses present?	_____	_____	_____
Is hair present on the feet?	_____	_____	_____
Does patient complain of pain or tingling in the feet?	_____	_____	_____
Can the patient see the bottom of the foot?	_____	_____	_____
Does the patient see a podiatrist?	_____	_____	_____
Does the patient need a podiatry referral?	_____	_____	_____
Is the patient wearing proper footwear?	_____	_____	_____

Describe foot care done at home by the patient: \_\_\_\_\_

MONOFILAMENT TEST: Note (-) NO RESPONSE (+) HAS RESPONSE

\_\_\_\_\_ Comments:



Signature: \_\_\_\_\_ Date: \_\_\_\_\_