

Diabetes & Nutrition Education 9000 Franklin Square Dr.-1CA Baltimore, MD 21237 443-777-6528 PHONE 443-777-8039 FAX franklinsquare.org

Thank you for choosing the Diabetes & Nutrition Education Center for your nutrition management needs.

Our office is located at: MedStar Franklin Square Medical Center

9000 Franklin Square Drive Baltimore, MD 21237 Main Entrance

Please enter through the main entrance and check in with the front desk. They will direct you to our office once you have registered with them.

Please arrive 15 minutes prior to your appointment time to allow for the registration process.

#### You will need to bring:

- Insurance Card(s), along with photo identification
- Completed Health History information found in this packet.
- Signed Copy of the Attendance Policy included in your packet

For <u>Diabetes Education Patients</u>- please bring your completed paperwork, your glucose meter, log book and supplies if you are already testing your blood sugar. This appointment is for education; you may eat and drink prior to your appointment.

For <u>Bariatric Patients</u>- please bring completed paperwork, any food logs you have completed, and your class binder.

A support person is welcome to attend the visit if you choose.

#### Parking:

You may park at a fee at any of the following locations:

- Visitor Parking Lot-off of Franklin Square Drive (Maximum Charge- \$8)
- Entrance 1 Outpatient and Surgical Services (Maximum Charge- \$8)
- Valet Parking is available from 9:00am-5:00pm at Entrance 2 for a \$5 fee.
- Street Parking is free and available on a first come, first serve basis

If you are unable to keep your appointment please contact the Diabetes & Nutrition Education Center at 443-777-6528. We look forward to working with you.

Thank you,

The Diabetes and Nutrition Education Center Staff



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### **Attendance Policy**

Thank you for choosing The Diabetes and Nutrition Center at MedStar Franklin Square Medical Center for your nutrition needs. We are pleased that you and your physician have chosen us to be a part of your treatment process. Please read, fill out and sign where applicable all forms that are attached and bring them with you to your appointment along with your insurance cards and photo identification.

Regular attendance is very important for your treatment. Please call in advanced whenever possible to cancel your appointment at 443-777-6528. If you need to call after our normal business hours, please leave a message for our staff informing us of your cancellation.

If you miss two (2) consecutive appointments without calling to cancel or three (3) appointments in a two week period, we will assume you have decided to decline our services and your physician will be notified. Any further appointments will require you to obtain a new physician referral/order.

Additionally, if you are late for your appointments by 15 minutes or more, you risk the chance that we may not be able to accommodate you upon your arrival and your appointment will be rescheduled for a later date and time.

During inclement weather please contact our office before you leave home or work for your appointment to ensure that our office is still operating under our normal hours of operation.

We look forward to working with you.

Date:	Person completing form:	Relationship to patient:
Signature:		
Date:	Staff reviewer signature:	



**Health History Assessment** 

Diabetes and Nutrition Education Center 9000 Franklin Square Dr. Franklin Square
Hospital Center

9000 Franklin Square Dr.
Baltimore, Maryland 21237-3988
Phone 443-777-6528 Fax 443-777-8039

## **Bariatric Health History Assessment**

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To complete put an X in t	he $\square$ and fill in line w	vhere appro	priate		
Do you have any of the fol	lowing?				
☐ Eye Problems:		☐ Heart Problems:			
☐ Kidney Problems:		☐ Stomach Problems:			
□ Numbness/Pain:		☐ Urinary Incontinence:			
Do you use/have history of	•				
Type?	Н	ow Much?		How Long?	
Tobacco:					
Alcohol:					
Drugs:					
Are you being treated for:	High blood pressur	e? 🗆 Yes	$\square$ No		
	High cholesterol?	☐ Yes	$\square$ No		
	High triglycerides?	□ Yes	□ No		
List any other medical pro	blems not listed abo	ove: _			

Previous surgeries (please list all):

Date: \_\_\_\_\_ Person completing form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date/Time: \_\_\_\_\_ Staff reviewer signature: \_\_\_\_



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# **Bariatric Health History Assessment**

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# **Patient Medication Summary**

Please complete the chart bel List all medications, vitamins,	Reason for taking	How often	Amount you take
ninerals, or herbal supplements	reason for taking	now often	Amount you take
ou are taking.		<u> </u>	
•		·	
•			
•	18	<u> </u>	
•			
•			
0.			
1.		·····	
2.			
3.			



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# **Bariatric Health History Assessment**

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To complete, put an "x" in the  $\square$  where appropriate or fill in the blank line.

I.	GENERAL INFORMATION	Date:
1.	Name:	
2.	Occupation:	
3.	Your Primary Physician's Name:	
4.	How did you hear about our program?	
5.	How many people live in your household?	
6.	How do you learn best? ☐ Pictures ☐ Reading	☐ Listening ☐ Demonstration
7.	What do you want to learn today?	
8.	Have you ever been physically abused?  Yes	No
9.	Have you ever been touched in a way that makes y	ou uncomfortable?   Yes   No
10.	Do you have money concerns that may limit your a	ability to manage your health?   Yes   No
II.	PHYSICAL EXERCISE	
1.	How active are you during the day?   Mostly site	ing $\Box$ On my feet most of the day
2.	Do you exercise? $\square$ Yes $\square$ No If Yes, what type	es(s) $\square$ Walking $\square$ Bicycling $\square$ Exercise Machine
	☐ Swimming ☐ Sports ☐ Other	
3.	How many times a week do you exercise? $\square$ 0 $\square$	1-2 □ 3-4 □ 5-6 □ More than 6
4.	How many minutes do you exercise at each time?	□ 0 □ 1-10 □ 11-15 □ 16-29 □ More than 30
5.	List any limitations for exercise:	
6.	Do you have any problems with balance?	□ No
7.	Do you have any problems walking?	s 🗆 No
8.	Do you use assistive devices for mobility?   Yes	s 🗆 No
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## **Bariatric Health History Assessment**

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III.	NUTRITION				
1.	Height Weight today				
	Has your weight changed recently?   Yes   No Lost pounds   Gained pounds				
2.	How often do you eat/drink the following foods each week?				
	FruitJuiceVegetablesCheeseSweets				
	Beverages with caffeine Beverages with sugar Water				
3.	. What type of milk do you drink? $\square$ Whole $\square$ 2% $\square$ 1% $\square$ Fat free.				
	How many cups of milk do you drink per day? Cups Don't drink milk				
4.	Who does the cooking?Who does the grocery shopping?				
5.	What type of meat do you buy? ☐ Whatever is on sale ☐ Whatever looks good ☐ Labeled lean or low-fat				
6. How is your food usually prepared?   Fried Baked Broiled Grilled					
	Do you add fat to your cooking?				
	What fats do you add when cooking?  Butter Oil Margarine Ham hocks Non-stick pan spray				
7.	How many times during a week do you eat out or carry out from the following:				
	Cafeteria-style? Fast food Sit down restaurant? Buffet? Other?				
8.	What best describes your eating habits? (check all the apply)				
	☐ No set meal or snack times ☐ Often skip breakfast ☐ Snack in the morning				
	☐ Snack or "graze" all day long ☐ Usually eat one meal a day ☐ Snack in the afternoon				
	☐ Usually eat three meals a day ☐ Snack before bed				
9.	List any food allergies or intolerance or special diet needs:				
10.	How do moods/stress affect your eating?				

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**Bariatric Health History Assessment** 

# IV. NUTRITION

If you skip a meal or snack, write skip.	Snack	Time
f you skip a meal	Dinner	Time
	Snack	Time
eals and snacks on a meals and snacks.	Lunch	Time
usually eat for meet time you eat your	Snack	
Please list what you usually eat for meals and snacks on an average day. Please also record the time you eat your meals and snacks.	Breakfast	Time:



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## **Nutrition Health History Assessment**

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V.	PREGNANCY (WOMEN COMPLETE, IF PREGNANT)	
1.	Is this your first pregnancy?	
2.	Number of weeks pregnant:Estimated due date:	
3.	Weight at start of pregnancyUsual weight when not pregnant:	
4.	How much weight did you gain with previous pregnancies?	
5.	Did any of your babies weigh more than 9 pounds?	
6.	I have:Gestational DiabetesGestational Diabetes with a previous pregnancyExcessive Weight GainI don't knowOther	
7.	If you don't drink milk, will you take a calcium supplement \( \text{Yes} \) No, or eat diet yogurt \( \text{Yes} \) No.  Thank you for completing this assessment.  Please bring it with you for your first visit.  THE FOLLOWING IS TO BE COMPLETED BY THE ENDOCRINE & DIABETES CENTER STAFF:	).
VI.	. EDUCATIONAL NEEDS	
	General Nutrition	
	Heart Healthy Eating   Foods for a Healthy Pregnancy	
	Pre-Diabetes Other	
	Educator's Cianatura	
	Educator's Signature Date and Time Reviewed with Patient	