MedStar Franklin Square Medical Center

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 **Diabetes Education Patients**- 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 **Bariatric Patients**- 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: ____

Franklin Square Hospital Center
MedStar Health

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Health History Assessment

To complete put an X in the ☐ and fill in line where appropriate

Do you have any of the following?

☐ Eye Problems: ____________________ ☐ Heart Problems: ____________________

☐ Kidney Problems: ____________________ ☐ Stomach Problems: ____________________

☐ Numbness/Pain: ____________________ ☐ Urinary Incontinence: ____________________

Do you use/have history of:

	Type?	How Much?	How Long?
Tobacco:	____________	____________	____________
Alcohol:	____________	____________	____________
Drugs:	____________	____________	____________

Are you being treated for:
High blood pressure? ☐ Yes ☐ No
High cholesterol? ☐ Yes ☐ No
High triglycerides? ☐ Yes ☐ No

List any other medical problems not listed above: ____

____

Previous surgeries (please list all): ____

Date: ________ Person completing form: ____________________ Relationship to patient: __________

Date/Time: ______________ Staff reviewer signature: ______________________________

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Patient Medication Summary

Any food or drug allergies? ☐ Yes ☐ No
Do you wear a medical identification bracelet or necklace? ☐☐ Yes ☐☐ No
Allergy / Reaction:______________________________

____

Please complete the chart below

List all medications, vitamins, minerals, or herbal supplements you are taking.	Reason for taking	How often	Amount you take
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Date/Time:_____ Person completing form:______________________________
Relationship to patient:______________________________
Date/Time:_____ Staff Reviewer signature:______________________________

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Patient Label

Diabetes Health History Assessment

To complete put an "x" in the ☐ box where appropriate or fill in the blank line.

GENERAL INFORMATION

Date:__________

1. Name:______________________ Age:__________
2. Occupation:______________________ Work hours:__________
3. Last grade of school completed:__________ Language of choice:__________
4. Your primary physician's name:______________ Phone number:__________
5. Your diabetes physician's name:______________ Phone number:__________

SOCIAL HISTORY

1. How many people live in your household?_____ Is there anyone who will help you with your diabetes care? ☐ Yes ☐ No If yes, who? __________
2. Are you currently in any major stressful situations? ☐ Yes ☐ No
   If yes, explain:__________
3. What do you do to relax and handle the stress in your life? __________
4. Do you feel very depressed or blue? __________
5. Have you ever been physically abused? ☐ Yes ☐ No
6. Have you ever been touched in a way that makes you uncomfortable? ☐ Yes ☐ No

HEALTH HISTORY

1. How long have you had diabetes? _____years _____newly diagnosed
2. What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Don't know
3. Do any of your family members have diabetes? ☐ Yes ☐ No
4. In your own words, what is diabetes? __________
5. How do you feel about having diabetes? __________
6. What do you think caused your diabetes? __________
7. Have you received diabetes education or diet education in the past? ☐ Yes ☐ No
8. How do you learn best? ☐ written materials ☐ verbal discussions ☐ video

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Patient Label

Diabetes Health History Assessment

9. What areas of diabetes would you like to learn more about?

   ☐ what is diabetes ☐ diet ☐ pregnancy and diabetes
   ☐ pills for diabetes ☐ exercise ☐ blood testing ☐ weight management
   ☐ high blood sugar ☐ stress ☐ complications
   ☐ low blood sugar ☐ sick days ☐ insulin/ pumps

10. My diabetes has caused a problem in the following areas:

    ☐ work/school ☐ travel ☐ family life/social activities
    ☐ sports/exercise ☐ sexual relations ☐ finances* ☐ other

    *If yes, do you require financial assistance? ☐ Yes ☐ No

11. How often do you have a physical examination?__________________ Date of last exam:__________
12. How often do you have your eyes checked? __________________ Date of last exam:__________
13. Do you wear glasses or contacts? ☐ Yes ☐ No
14. Have you noticed any changes in your skin recently? ☐ Yes ☐ No

    If yes, please describe:____
15. How often do you check your feet?______________________________________
16. Date of last foot exam by MD: ______________ Do you have a podiatrist (foot doctor)? ☐ Yes ☐ No
17. How often do you have a dental check-up?_________________________________
18. Have you ever had a shot to prevent pneumonia? ☐ Yes ☐ No
19. Have you received a flu shot within the year? ☐ Yes ☐ No

DIABETES MEDICATION

1. Have you ever forgotten to take your diabetes medication? ☐ Yes ☐ No

   If yes, what did you do?____
2. If you take insulin, do you inject insulin with: ☐ a syringe ☐ an insulin pen ☐ an insulin pump

   Who fills the syringe? __________________Who gives the injection? ____________________
3. Where do you inject your insulin? ☐ stomach ☐ arm ☐ thigh ☐ hip ☐ other__________________
4. Do you reuse your syringes? ☐ Yes ☐ No If yes, how often? ______________________
5. Where do you dispose of your syringes? ___________________________________
6. Where do you keep your insulin? ____________________

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Diabetes Health History Assessment

MONITORING CONTROL

1. How often do you check your blood sugar?________________________ ☐ Don't Check
2. What blood sugar machine or meter do you use? ________________________
   Usual results:________________________
3. Do you keep a written record? ☐ Yes ☐ No What is your blood sugar goal? ________________
4. What was your last A1C result? ______________

HIGH AND LOW BLOOD SUGAR

1. When you have a low blood sugar reaction how do you feel? ________________________
   How did you treat it? ________________________
2. Do you carry a source of sugar with you? ☐ Yes ☐ No
3. When you have high blood sugar how do you feel?________________________
   What do you do to treat it?________________________

PHYSICAL ACTIVITY

1. How active are you during the day? ☐ Mostly sitting ☐ On my feet most of the day
2. Do you exercise? ☐ Yes ☐ No Type of exercise(s): ________________________
   How often? __________How long? ____________Time of day?________________
3. List any limitations for exercise: ________________________
4. Do you have any problems with balance? ☐ Yes ☐ No
5. Do you have any problems walking? ☐ Yes ☐ No
6. Do you use assistive devices for mobility? ☐ Cane ☐ Walker ☐ Wheelchair

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NUTRITION

1. Height__________ Weight__________ What weight are you comfortable at? ______________

   Has your weight changed in the past three months? ☐ Yes ☐ No

   If yes, I've lost / gained (please circle) ________ lbs.

   Was the weight change intentional? ☐ Yes ☐ No

2. How often do you eat/drink the following foods each week?

   Fruit:___________ Juice:___________ Milk: fat free _____ 1% _____ 2% _____ whole_______

   Vegetables:________ Cheese:__________ Sweets:_________ Sugar free desserts:____________

   Beverages with sugar:______________ Water:_________ Alcohol:_________

3. Who does the cooking?____

4. What type of meat do you buy?

   ☐ Whatever is on sale ☐ Whatever looks good ☐ Labeled lean or low-fat

   Do you trim the fat off your meat? ☐ Yes ☐ No

5. How is your food usually prepared? ☐ Fried ☐ Baked ☐ Broiled ☐ Grilled

   Do you add fat to your cooking? ☐ Yes ☐ No What fats do you add when cooking?

   ☐ Butter ☐ Oil ☐ Margarine ☐ Fatback/streak of lean ☐ Hamhocks

6. How many times during a week do you eat out? ________________________________

   How often is your meal away from home: Cafeteria-style? _________ Fast food? ____________

   Sit down restaurant? _________ Buffet? _________ Other? _________

7. How would you describe your portions? ☐ Small ☐ Average ☐ Large

8. Any other special dietary needs: ☐ Low fat ☐ Low sodium ☐ Lactose free

   Religious observances (list):____

   ☐ Other (list):____

9. How do moods / stress affect your eating?___________________________________

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Patient Label

Diabetes Health History Assessment

List what you usually eat for meals and snacks on an average day. If you skip a meal or snack, write skip.
Please be honest since we will try to plan your meal plan around your usual intake if possible.
Record the time you eat your meals and snacks.

Breakfast	Snack	Lunch	Snack	Dinner	Snack
Time:________	Time________	Time________	Time________	Time________	Time________

What time do you take your diabetes medications? ____________________

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PREGNANCY (WOMEN ONLY) Complete only if you are of child bearing potential.

1. Are you currently pregnant? ☐ Yes ☐ No If yes, what is your due date? ____________
2. Are you planning to become pregnant? ☐ Yes ☐ No
3. Have you ever been pregnant? ☐ Yes ☐ No

   If yes, how many times? _____How many live births? _____

   How many of your babies weighed more than 9 pounds?________
4. Are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes? ☐ Yes ☐ No
5. What method of birth control do you use? ____

Thank you for completing this assessment.
Please bring it with you for your first visit.

BELOW LINE TO BE COMPLETED BY THE DIABETES AND NUTRITION EDUCATION STAFF

EDUCATIONAL NEEDS

Check all that apply:

☐ Diabetes disease process
☐ MNT(Medical Nutrition Therapy)
☐ Physical activity
☐ Medications
☐ Monitoring
☐ Hypoglycemia, DKA, HHNC
☐ Chronic complications
☐ Goal setting and problem solving
☐ Psychological adjustment
☐ Preconception care, pregnancy, GDM

____
Educator's Signature

____
Date and Time Reviewed with Patient