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: _____

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Gestational Diabetes Health History Assessment

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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Gestational Diabetes Health History Assessment

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

I. GENERAL INFORMATION

Date: _____

1. Name: _____ Age: _____
2. Occupation: _____ Work Hours: _____
3. Your Primary Physician's Name: _____ Phone Number: _____
   Your Diabetes Physician's Name: _____ Phone Number: _____
4. How did you hear about our program? _____
5. How many live births? _____ How many of your babies weighed more than 9 pounds? _____
6. Number of weeks of pregnancy? _____ Estimated Due Date: _____
7. Are you aware of the effects of diabetes on pregnancy? ☐ Yes ☐ No
8. Do any of your family members have diabetes? ☐ Yes ☐ No

II. SOCIAL HISTORY

1. How many people live in your household? _____
2. Is there anyone who will help you with your diabetes care? ☐ Yes ☐ No If yes, who? _____
3. Are you currently in any major stressful situation? ☐ Yes ☐ No
   If yes, explain: _____
4. What do you do to relax and handle the stress in your life? _____
5. Do you feel very depressed or blue? _____
6. Have you ever been physically abused? ☐ Yes ☐ No
7. Have you ever been touched in a way that makes you uncomfortable? ☐ Yes ☐ No
8 How do you learn best? ☐ Reading ☐ Listening ☐ Demonstration ☐ Pictures/video
9 What do you want to learn today? _____
10. My diabetes has caused a problem in the following areas:
    ☐ Work/School ☐ Family life/Social activities ☐ Other
    ☐ Sports/Exercise ☐ Sexual relations ☐ Finances* ☐ Travel
11. Do you have money concerns that may limit your ability to manage your health? ☐ Yes ☐ No

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III. NUTRITION

1. Height: _____ Weight today: _____ Weight at start of pregnancy: _____

   Usual weight when not pregnant: _____

   Have you gained or lost weight (or both) with this pregnancy?_____

   Do you drink juice, regular soda, or other drinks containing sugar such as punch, iced tea, lemonade or sports drink? ☐ Yes ☐ No

2. What type of milk do you drink? ☐ Don't drink milk ☐ Whole ☐ 2% ☐ 1% ☐ Fat-free

   How many cups of milk do you drink per day? _____

   You should drink 3-4 cups of milk per day. If you do not, is this possible? ☐ Yes ☐ No

   If no, how much could you drink? ____ Cups per day

   Could you use diet yogurt instead of milk? ☐ Yes ☐ No

   If you do not drink enough milk, will you take a calcium supplement? ☐ Yes ☐ No

4. Who does the cooking? _____

5. What type of meat do you buy? ☐ On sale ☐ Looks good ☐ Labeled lean or low-fat

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

6. 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 ☐ Ham hocks

7. 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? _____

8. How would you describe your portions? ☐ Small ☐ Medium ☐ Large

9. List any food allergies or intolerance:_____

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

    Religious observances (list): _____Other (list):_____

11. How do moods/stress affect your eating? _____

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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:_____

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IV. 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 If Yes, what 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? ☐ Yes ☐ No If Yes, what type? _____

V. MONITORING CONTROL

1. How often do you check you blood sugar: _____ ☐ Don't Check
2. Which blood sugar meter do you use? _____
   Usual results: _____
3. Do you keep a written record? ☐ Yes ☐ No What is your blood sugar goal?_____

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

VI EDUCATIONAL NEEDS

- ☐ Gestational diabetes disease process
- ☐ MNT
- ☐ Physical activity
- ☐ Insulin
- ☐ Diabetes prevention
- ☐ Hypoglycemia, DKA, HHNK
- ☐ Monitoring
- ☐ Goal setting and problem solving
- ☐ Psychological adjustment

_____ Educator's Signature

_____ Date and Time Reviewed with Patient