For age **12 and older**

Welcome to the Madison Clinic at UCSF!

Parent and child, or adult patient: please complete this Health Survey to help us to best serve your needs. The term "you" refers to the patient.

Name:____Date:__________

HISTORY

Date of birth:____________ Gender: ☐M ☐F

You have ☐Type 1 diabetes ☐Type 2 diabetes ☐ Not sure/other____________

Year diagnosed?_________ Age at diagnosis:_____

Any other health problems? ☐No ☐Yes What?__________________________________

What is your preferred language for discussing healthcare?

☐English ☐Spanish ☐Other:_____________________

Who is responsible for diabetes care at home? __________________________________

Whom do you live with?____

Any family members with diabetes? ☐No ☐Yes Who?_____________________________

Have you ever had diabetes education before? ☐No ☐Yes Where? _________________

Who has provided you with diabetes information in the past? ☐N/A

☐Primary Care Doctor ☐Endocrinologist ☐Nurse educator

☐Registered dietitian ☐Social Worker ☐Other

School or College name:___________________________ City:_______________

MEDICATIONS

What prescriptions do you need today? ☐None ☐The following: ____________________

____

Do you use: ☐injections ☐insulin pump (type:_________________)

☐ pills (which)______________________________ ☐ other_______________

Do you know how to adjust medications for food and exercise? ☐No ☐Yes

MONITORING

Which blood glucose monitor(s) do you use?____________________________________

How often do you check your blood sugar?_____________________________________

Do you use a continuous glucose monitor (CGM)? ☐No ☐Yes

Date of last A1C? _________ Result:________ ☐Unsure ☐Don't know what A1C means

INFORMATION

What would you like to learn more about?

☐Counting carbohydrates ☐Healthy eating ☐Balanced meal planning ☐Label reading

☐Weight control ☐Exercise ☐Checking blood sugar ☐Problem solving blood sugars

☐Ketones ☐Insulin dosing ☐Other medications ☐Reducing risks for complication

☐Insulin pumps ☐Continuous glucose monitoring ☐Stress management ☐Support groups

☐504 School Plan ☐Diabetes studies ☐Transitioning to adult care ☐Other: ___________

HEALTHY EATING

What is your main nutrition concern?____

Do you count carbohydrates? ☐No ☐Yes

On average, how many grams of carbs per meal?__________, per snack?__________

What resources do you use? ☐Carbohydrate counting list or book ☐Measuring cups

☐Food scale ☐Websites ☐Phone apps ☐Other:_____________

Patient label

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BEING ACTIVE

Do you exercise regularly? ☐No ☐Yes, What type?________________________
For how many minutes? _______________ How many times per week? ________

HEALTHY COPING

Overall, describe your general feeling: ☐OK ☐ Cheerful ☐ Stressed out ☐ Depressed
From whom do you get support for your diabetes?
☐Family ☐Friends ☐No one ☐Other____
Do you have enough money for food and medical supplies? ☐No ☐Yes
Do you have any concerns about your weight? ☐No ☐Yes

REDUCING RISKS

Do you smoke or have second-hand exposure? ☐No ☐Yes Describe: __________________
Have you ever had DKA? ☐No ☐Yes, date(s):________ ☐Unsure ☐Don't know what DKA is
Do you ever check for ketones? ☐No ☐Yes How?__________________________________
Do you wear medical identification? ☐No ☐Yes What?____________________________
Do you carry anything to treat your lows with? ☐No ☐Yes What?_____________________
Where do you discard used lancets and needles? ☐Sharps container ☐Garbage ☐Other

Mark which of the following you have had in the past 12 months:
☐Cholesterol labs ☐Celiac screening labs ☐Thyroid labs ☐Dilated eye exam ☐Dental visit
☐Urine test for protein ☐Foot exam ☐Flu shot ☐Pneumonia vaccination
☐Emergency room visit:__________________ ☐Hospital admission :___________________

PROBLEM SOLVING

Do you have a glucagon kit? ☐No ☐Yes (Expiration date:_____________)
Do you know how to use the glucagon kit? ☐No ☐Yes
[If you are not currently checking blood sugar, skip to next section.]

In the last week, have you had a low blood sugar? ☐No ☐Yes: how many times___☐Unsure
Do feel your low blood sugars? ☐No ☐Yes If so, at what blood sugar level?____________
What are your symptoms?____
How do you treat your low blood sugars?____
Have you ever needed glucagon to treat low blood sugar? ☐No ☐Yes, date(s):__________
Have you ever passed out, had a seizure from, or needed 9-1-1 assistance for low sugar?
☐No ☐Yes, date(s):_________
How do you treat your high blood sugars?____

QUESTIONS FOR TEENS AND OLDER

Do you work or volunteer? ☐No ☐Yes (Job:_____________________________________)
Do you check your blood sugar before driving? ☐No ☐Yes ☐Sometimes ☐N/A

Anything else you'd like us to know?____

Thank you!

Staff notes: ____
Reviewed by Staff (print):___________________________Initials:_____Staff Signature:_________________

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Full Patient Name or label