Welcome to the Madison Clinic for Pediatric Diabetes at UCSF!

Parent/guardian: please complete this Health Survey to help us to best serve your child's needs.

Child's Name:_____Your Name:_____Date:_____

For age **11 and younger**

CHILD'S HISTORY

Date of birth:_____ Gender: ☐M ☐F

Type of diabetes? ☐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 and your child live with?_____

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

Has your child 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 name:_____

City:_____ School phone (if known): _____

MEDICATIONS

What prescriptions does your child need today? ☐None ☐The following: _____

_____

Does your child 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) does your child use?_____

How often do you check your child's blood sugar?_____

Does your child 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

BEING ACTIVE

Does your child exercise regularly? ☐No ☐Yes, What type?_____
For how many minutes? _____ How many times per week? _____

HEALTHY COPING

Overall, describe your child's general feeling:☐OK ☐ Cheerful ☐ Stressed out ☐ Depressed
From whom do you and your child get support for 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 child's weight? ☐No ☐Yes

For age **11 and younger**

REDUCING RISKS

Is your child exposed to second-hand smoke? ☐No ☐Yes Describe: _____
Has your child had DKA? ☐No ☐Yes, date(s):_____ ☐Unsure ☐Don't know what DKA is
Do you ever check your child's ketones? ☐No ☐Yes How?_____
Does your child wear medical identification? ☐No ☐Yes What?_____
Do you carry anything to treat your child's lows with? ☐No ☐Yes What?_____
Where do you discard used lancets and needles? ☐Sharps container ☐Garbage ☐Other

Mark which of the following your child has 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

Does your child have a glucagon kit? ☐No ☐Yes (Expiration date:_____)
Do you know how to use the glucagon kit? ☐No ☐Yes
[If you are <u>not</u> currently checking blood sugar, skip to next section.]

In the last week, has your child had a low blood sugar? ☐No ☐Yes: how many times?___
☐Unsure
Does your child feel low blood sugars? ☐No ☐Yes If so, at what blood sugar level?_____
What are your child's symptoms?_____
How do you treat your child's low blood sugars?_____
Have you ever used glucagon to treat your child's low blood sugar? ☐No ☐Yes, date(s):____
Has your child ever passed out, had a seizure from, or needed 9-1-1 assistance for low sugar? ☐No ☐Yes (date:_____)
How do you treat your child's high blood sugars?_____

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