DIABETES REFRESHER CLASS ASSESSMENT

Today's Date_____

Demographic information:

Name_____ Date of birth_____

Doctor _____

Medical information:

Height _____ Weight _____ How long have you had diabetes? _____

Age_____ Do you smoke? _____

Other medical conditions- Circle all that apply:

High blood pressure	Heart problems	Dental problems
High cholesterol	Kidney problems	Yeast Infections
Sleep Apnea	Nerve Problems	Erectile Dysfunction
Gastroparesis	Circulation problems	Congestive Heart Failure

Medical conditions not mentioned above: _____

Any allergies to food or medicines? _____

Diabetes information:

What meal plan are you using right now? _____

What is your biggest challenge when it comes to food?_____

What is your current exercise program? _____

Are you satisfied with your weight? _____

What is the name of your blood sugar machine? _____

What time(s) of day do you test your blood sugar? _____

What are your lowest & highest blood sugar numbers? _____

What is the hardest part about having diabetes? _____

List the **DIABETES** medications that you are currently taking.

List doses and how often you take them.

1.
2.
3.
4.
5.
6.

DTC Use Only

Provider's signature_____ Revised 1/2021