St. Francis Hospital
DIABETES TREATMENT–
EAST MEDICAL OFFICE BUILDING

DIABETES REFRESHER CLASS ASSESSMENT

Date: _____

Demographic information:

Name_____ Date of birth_____
Address_____
Cell phone_____ Home phone_____ Work phone _____
Email_____ Doctor _____
How would you prefer to be contacted? (Circle) Cell Home Work Email

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 medications? _____

Diabetes information:

What meal plan are you using right now? _____
What is your current exercise program? _____
Are you satisfied with your weight? _____
Which blood sugar machine do you have? _____
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 all medications that you are currently taking. List doses and how often you take them. (Including insulin, water pills, vitamins/herbal supplements)

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

DTC Use Only

Provider's signature_____

2093 Henry Tecklenburg Drive, Ste. 201
Charleston, SC 29414
Phone (843) 402-1099
Fax (843) 402-1236