COASTAL BEND HEALTH EDUCATION CENTER
TEXAS A&M UNIVERSITY

DIABETES EDUCATION PROGRAM

Class Type:	Class Date:	Assessment Date:

Community Diabetes Program Participant Information Sheet

Name:		Date of Birth:	
Address:	City:	State:	Zip Code:
County:	Social Security Number:		
Phone Number: Home:	Work:	Cell:	
Emergency Contact: Name:	Phone Number:	Relationship:	

Language: ❒ English ❒ Spanish ❒ American Sign Language ❒ Other: ____________________

Present Employment: ____________________ Occupation: ____________________ Retired : ❒ Yes ❒ No

Education: ❒ No HS ❒ GED ❒ HS ❒ Associates ❒ Bachelors ❒ Grad Degree

Do you have: ❒ Visual Problems ❒ Hearing Problems ❒ Reading Problems ❒ Problems with Understanding English

Other problems that may make learning difficult: ____

Ever used a computer? ❒ Yes ❒ No Access to: ❒ Computer ❒ Internet ❒ Email

Gender: ❒ Male ❒ Female Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed

Race/Ethnicity: ❒ White ❒ Hispanic ❒ African American ❒ Asian/Pacific Islander ❒ Other

Who helps you if you need help? ____

My Health History: I have: ❒ Diabetes ❒ Heart Disease ❒ Cancer ❒ High Blood Pressure

What type of diabetes do you have? ❒ Type 1 ❒ Type 2 ❒ Pre-diabetes ❒ Gestational ❒ Don't Know

I have had diabetes for __________Months / __________Years

Do you own a glucometer? ❒ Yes ❒ No What brand? ______________________________

Do you check your blood sugars? ❒ Yes ❒ No

Attended classes: ❒ Diabetes Class How long ago? _________ ❒ Weight Control ❒ Glucose Monitoring

❒ Exercise ❒ Dietary Counseling ❒ Smoking Cessation

Check any of the following tests/procedures you have had in the last 12 months:

foot exam: ❒ self or ❒ healthcare professional ❒ dilated eye exam ❒ urine test for protein ❒ dental exam ❒ HgA1c

❒ blood pressure ❒ weight ❒ cholesterol ❒ flu shot ❒ pneumonia shot ❒ lipid profile ❒ cardiac profile

Do you smoke? ❒ Yes ❒ No How long have you smoked? ______ Number of packs smoked per day ______

Do you drink alcohol? ❒ Yes ❒ No How many drinks do you drink per week? __________

What do you think is most important for you to learn in this class? ______________________________

Patient Name:	Date of Birth:	Class Date:

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Nutrition:

Do you like fruits and vegetables? ❐ Yes ❐ No					
How many fruits and vegetables do you eat on a typical day? (Circle one)	0	1 - 2	3 - 4	5 +	Not Sure

Physical Activity:

How many minutes were you physically active yesterday? ___________ Minutes
What type of exercise do you do?
Is there a particular reason you cannot exercise? If so, list:

Referring Source: ❐ Physician ❐ Friend/Family ❐ Internet ❐ Flyer ❐ Screening Event ____________________________
Referring Physician: ___________________________________ and/or **Clinic/Hospital:** _________________________

Insurance Provider:

❐ Private Insurance: ___________________________ ❐ Medicare ❐ Medicaid ❐ NCHD ❐ Other Indigent Program

❐ No Insurance **If no insurance, please answer the following:**

Have you enrolled in Obama Care? ❐ Yes ❐ No If No, why? ____

How many people live in your household? ______ What is your annual income? $_________ or monthly $_________

How would you rate your general health? ❐ Excellent ❐ Good ❐ Fair ❐ Poor

Family History: My parent, grandparent or brother or sister has or had:

❐ Diabetes ❐ Heart Disease ❐ Cancer ❐ High Blood Pressure

Please describe the reason for all hospital or emergency room (ER) visits in the past year:

Overnight hospital stay: ____

Emergency room visit: ____

Have you lost any days of work due to diabetes? ❐ Yes ❐ No

Have you had any low blood sugars? ❐ Yes ❐ No Explain:____

____

____

I do hereby release and forever discharge the TAMHSC, Coastal Bend Health Education Center and any participating program of the Coastal Bend Health Education Center together with such agents, employees, associates, volunteers, successors, assigns, and affiliates from and for any and all liability, claims or causes of action of any nature whatsoever arising out of, or resulting from, any injury, illness, loss or damage, including death, which I may incur as a result of, or in connection with, the performance of said examinations/screening tests, or from the data derived there from.

Signature:____ **Date:** _____________________________________

Person that completed this form: ____________________________ **Relationship to patient:** __________________

For office use only:

Below 200% poverty level: ❐ Yes ❐ No