



**Class Date:** \_\_\_\_\_ **MRN#:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Address:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Phone:( )** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Diabetes Doctor:** \_\_\_\_\_

**Have you been to diabetes education before?** Yes No **If yes, When?** \_\_\_\_\_

**If someone is coming to class with you, what is your relationship?** \_\_\_\_\_

**Medical History** \_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

**Type of Diabetes:** Type 1 Type 2 Pre-Diabetes Other **Diagnosis year:** \_\_\_\_\_

**Circle medical history:**

- |                     |                |                |
|---------------------|----------------|----------------|
| Heart Disease       | Kidney Disease | Slow Digestion |
| High Blood Pressure | Anxiety        | Eye Problems   |
| High Cholesterol    | Depression     | Skin Problems  |
| High Triglycerides  | Nerve Damage   | Foot Problems  |

**Do you use tobacco?** Yes / No **Circle all that apply.**

Cigarette E-Cigarette Chewing Cigar Pipe Date Quit: \_\_\_\_\_

**Circle if completed in the past 12-months:**

A1C (Result \_\_\_\_\_) Eye Exam Foot Check Flu Shot Cholesterol Teeth Cleaning

**Blood Sugars** \_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

**How often do you check blood sugar?** \_\_\_\_\_ **Do you keep a log?** Yes No

**What is your blood sugar at:** Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_ Bed \_\_\_\_\_

**What are your signs of HIGH blood sugar & how do you treat?** \_\_\_\_\_

**Do you test your Ketones?** Yes No Not Sure

**What are your signs of LOW blood sugar & how do you treat?** \_\_\_\_\_

**Do you have glucagon?** Yes No Not Sure **Is someone trained to use it?** Yes No

**Has EMS been called or have you gone to the hospital for high or low blood sugar?**

**Describe:** \_\_\_\_\_

NAME:

MRN:

Diabetes Medications \_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

List oral & injectable medicine you take for diabetes (you may also attach list)

Diabetes Medicine	Dose	Frequency

If you do not take insulin, skip to the next section

What do you inject insulin with? Insulin Pen Syringe & Vial Insulin pump

When do you take meal time insulin? Before Meals During Meals After Meals

Do you use an insulin to carb ratio? Yes No If Yes, Describe: \_\_\_\_\_

When & how do you decide to take extra insulin? \_\_\_\_\_

How often do you miss a dose of insulin? \_\_\_\_\_

List problems getting your diabetes supplies/medicine: \_\_\_\_\_

Nutrition \_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

How many days a week do you eat: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

How many regular sugar drinks do you consume weekly? \_\_\_\_\_ Alcoholic drinks? \_\_\_\_\_

Do you know how to carb count? Yes No

Feet/Exercise \_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

How often do you check your feet? Never Daily Monthly List problems: \_\_\_\_\_

What type of exercise do you do? \_\_\_\_\_

No. days/week? \_\_\_\_\_ Length? \_\_\_\_\_

\_\_\_\_\_ Independent \_\_\_\_\_ Needs Review \_\_\_\_\_ Needs Referral \_\_\_\_\_ Not Assessed

What are your feelings about diabetes? \_\_\_\_\_

Do you have any difficulty with: Seeing Hearing Reading Speaking Dexterity

What do you want to learn in session? \_\_\_\_\_

How willing are you to make changes to your lifestyle? (1= not willing, 5 = very willing) 1 2 3 4 5

NAME:

MRN:



**THE OHIO STATE UNIVERSITY**  
WEXNER MEDICAL CENTER

**DIABETES EDUCATION**

*At CAREPOINT EAST  
MARTHA MOREHOUSE  
INTERNAL MED HILLIARD  
RARDIN FAMILY PRACTICE  
COMPREHENSIVE TRANSPLANT*

Please **rate your knowledge** on each topic using a scale of 0 to 3.

0 = No knowledge

1 = Some knowledge

2 = I understand

3 = I am an expert

Before Class 1, fill out columns "Before Class" and "I want more information about this topic." At the end of class 2, fill out the column "After Class 2"

<b>TOPIC</b>	<b>Before Class 1</b>	<b>I want more information about this topic (check mark)</b>	<b>After Class 2</b>
I know the difference between Type 1 & Type 2 Diabetes			
I know how, when and why to check my blood sugar			
I know my target blood sugar and A1c level			
I recognize and can treat low and high blood sugars			
I can manage my diabetes when I am sick			
I am able to count carbohydrates and know which fats are heart healthy			
I recognize three reasons physical activity benefits me			
I can state my medicine and know why I am taking it			
I am aware of long-term and short-term complications			
I can identify how stress affects my diabetes			

## OSU Internal Medicine, LLC Group Visit Consent Form

Group visits are shared medical appointments in which multiple patients participate, sharing information about themselves and their medical status. Each patient's participation is strictly voluntary. The effectiveness of the group appointment is dependent upon a sharing of information by and among the participants. It is impossible to prevent protected medical information from being shared amongst the participants.

To be eligible to participate in a group medical visit, you must agree to respect the privacy of the other participants, and agree to keep their information confidential. Patients need to feel comfortable that they can participate in the group without their personal and medical information being shared outside of the group or used without their knowledge. You agree you will not make written notes, document or otherwise record any medical or personal information about group participants, without their written approval, and that you will not disclose any other participant's medical or personal information to any one outside of the group medical visit.

OSU Internal Medicine, LLC (OSU IM), as the sponsor of the group medical visit, requires participants to sign a confidentiality agreement stating they will not repeat or share protected medical information or other personal information outside of the group; however, we cannot guarantee that all participants in the group will comply with the terms of the confidentiality agreement. Participant agrees to accept this risk.

### ***Confidentiality Agreement and Consent***

*By signing this confidentiality agreement, I agree to keep all medical and personal information of group participants confidential. I agree that I may be excluded from the group if I fail to keep information confidential.*

*I agree to allow OSU IM to share my name and medical information during the group visit, including information on my health, nutritional and medical conditions.*

*I release OSU IM from any and all liability, claims, damages and/or expenses resulting from any other participant's violation of their confidentiality agreement.*

*This release shall be effective as long as I am participating in a group.*

**Name** (please print): \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_