



### PATIENT REGISTRATION

DATE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

Do you give DCC permission to use your email for general communication (you will only see your email address)? **Yes** **No**

**LAST NAME:** \_\_\_\_\_ **FIRST NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **AGE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PREFERRED CONTACT #:** \_\_\_\_\_ **RACE/ETHNICITY:** \_\_\_\_\_

**OCCUPATION:** \_\_\_\_\_ **LEVEL OF EDUCATION:** \_\_\_\_\_

**EMERGENCY CONTACT (& title:)** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**MARITAL STATUS:** \_\_\_\_\_ **INSURANCE CARRIER:** \_\_\_\_\_

**PHYSICIAN INFO:** Primary Care: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ PHONE: \_\_\_\_\_

**MEDICAL INFO:** TYPE 1  TYPE 2  PRE-DIABETES  GESTATIONAL  OTHER

Date of Diabetes Diagnosis: \_\_\_\_\_ Age at Diagnosis: \_\_\_\_\_ Do you wear diabetes identification? Yes \_\_\_ No \_\_\_

Have you had any diabetes education in the past? Yes \_\_\_ No \_\_\_ If yes, how long ago was it? \_\_\_\_\_

#### Monitoring & Medications:

Which blood glucose monitor do you use at home? \_\_\_\_\_ How often do you self-test? \_\_\_\_\_

Last Hgb A1C: \_\_\_\_\_ Date: \_\_\_\_\_ Do you check for ketones? Yes \_\_\_ No \_\_\_ Any known drug allergies? \_\_\_\_\_

Diabetes Meds type and dose: \_\_\_\_\_

Other Meds names and doses: \_\_\_\_\_

#### Complications:

How often do you experience low blood sugars? \_\_\_\_\_ High blood sugars? \_\_\_\_\_ History of DKA? \_\_\_\_\_

Any hospital-related stays in past year due to diabetes? (Please explain) \_\_\_\_\_

List current/past complications. \_\_\_\_\_

#### Lifestyle Habits:

Do you exercise regularly? Yes \_\_\_ No \_\_\_ What kind of exercise and duration? \_\_\_\_\_ Times a week? \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If yes, how much? \_\_\_\_\_ Do you drink alcohol? Yes \_\_\_ No \_\_\_ If yes, how often? \_\_\_\_\_

Do you take recreational drugs? Yes \_\_\_ No \_\_\_ If so, what kind and how often? \_\_\_\_\_

How often do you eat out? \_\_\_\_\_ How often do you do a self-foot check? \_\_\_\_\_

#### Teaching Plan:

What are your educational goals pertaining to diabetes? \_\_\_\_\_

What is your preferred method of learning? (ex: demonstration, reading, etc): \_\_\_\_\_

Do you have any barriers to learning? (ex: visual, language, etc): \_\_\_\_\_

Any additional comments: \_\_\_\_\_

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

**Diabetes Educator:** \_\_\_\_\_ **Date:** \_\_\_\_\_