KentuckyOne Health®

DIABETES AND NUTRITION CARE
HEALTH HISTORY & ASSESSMENT

Name: _____ DOB: _____

Do you currently have or have you had:	Yes	When were you diagnosed:	No
Vision Problems: other than near or farsightedness			
High Cholesterol			
Heart Attack			
High Blood Pressure			
Recent Surgery			

Do you use alcohol? ❒ NO ❒ YES If Yes, ❒ Every day or ❒ Every Week - ❒ 5-6 times ❒ 3-4 times ❒ 1-2 times ❒ once a week ❒ once a month or less

Have you had any recent surgery? ❒ NO ❒ YES What kind?_____

Do you have any physical limitations? ❒ NO ❒ YES What kind?_____

How do you learn best? ❒ Reading ❒ Class Demonstration ❒ Other:_____

Do you ever need help reading food labels and/or recipes? ❒ NO ❒ YES

Are you pregnant, or considering pregnancy? ❒ NO ❒ YES ❒ Doesn't apply to me

Do you have any current stressors? ❒ Family ❒ Friends ❒ Job ❒ Marriage ❒ Money Other:_____

In the past year have you had a major loss, or change in your life? ❒ NO ❒ YES

Medication: Please list all the medications you take with the amount and frequency and reason you take it. Include over the counter and herbal medicines. Use back of form if needed.

Medication Name	Amount and Frequency	Reason

DO NOT WRITE BELOW THIS LINE

Diabetic Record

F160

Reviewed By: _____ Date: _____