DIABETES DIET HISTORY FORM - ***Debra F. Latimer Nutrition and Diabetes Associates, LLC*** *(ver. 7.0)*

Name _____

Address _____ Appt. Date _____

_____ Age _____ DOB _____ Sex _____
City State Zip

Home # _____ Work # _____ Occupation _____

As part of our recognition status with the American Diabetes Association we are required to keep statistics on the ethnic diversity of our patient population. Please check the appropriate box.

_____ Caucasian _____ African American or Black _____ Hispanic or Latino _____ Asian or Pacific Islander
_____ American Indian or Alaskan Native

Physician's Full Name _____ Physician's # _____

Physician's Address _____
Street City State Zip

MEDICAL HISTORY/NUTRITION DIET HISTORY
How long have you had Diabetes? _____ Have you had any Diabetes Education? _____

If yes when and where? _____

Do you have any of the following conditions? (circle problems)

Obesity Heart Disease High blood pressure High Cholesterol High Triglycerides

Do you have any tingling or numbness in your hands, legs or feet? ___Yes ___No. Have you ever been diagnosed with Neuropathy? ___Yes ___No.

If yes, have you received treatment ___Yes ___No. If yes, describe treatment received or are currently receiving.

_____

_____

Have you ever been diagnosed with Diabetic Eye Disease (Retinopathy)? ___Yes ___No. Have you ever been told you are showing signs of Diabetic Eye Changes ___Yes ___No. If yes, what treatment have you received or are currently receiving.

_____

_____

Have you been diagnosed with Diabetic Kidney Disease (Nephropathy)? ___Yes ___No. If yes, what treatment have you received or are currently receiving.

_____

_____

Have you ever been told you have heart problems? ___Yes ___No. If yes, describe_____

_____. If yes, what treatments have you received or are currently receiving.

_____

_____

Have you ever suffered a heart attack ____Yes ___No. If yes, what treatment did you receive or are currently receiving.

_____

_____

Do you smoke? _____ What is your blood pressure? _____

What is your HA1C? _____ HDL _____ LDL _____ Total Cholesterol _____

List all other health problems and when diagnosed _____

_____ .

List all current prescriptions and dosages you are taking _____

_____

_____ .

Please list all over the counter medications, vitamins, minerals, herbs, etc. including dosages or amounts you are taking _____

_____.

How long have you been at your current weight? _____ yrs. _____ mths. _____
(non-pregnant weight)

Highest weight in past 10 years _____ When and How long maintained _____
(if pregnant, list highest non-pregnant weight)

Lowest weight in past 10 years _____ When and How long maintained _____
(if pregnant, list lowest non-pregnant weight)

What do you consider your ideal weight? _____ Have you ever been at this weight? _____
When and how long maintained? _____

Briefly describe any methods of weight reduction you have used in the past or are currently using: _____

_____

What do you feel is the main problem in achieving your ideal weight: (circle)

Boredom Late Night Snacking Snacking All Day Skipping Meals Binging Lack Of Exercise

Other _____

Have you ever followed a special diet in the past? _____ Describe _____

Who prescribed it? _____ How long followed? _____

Appetite: (circle one) Good Fair Poor

List food allergies: _____ Food dislikes: _____

FOOD FREQUENCE AND PREFERENCE LIST

Do you drink milk? _____ How many times per day? _____ or week _____

What kind? Whole _____ 2% _____ Skim _____ ½% _____

With what meal or snacks do you normally consume milk? _____

If you do not drink milk currently, would you be agreeable to try some on a daily basis? _____
If no, state reason _____

What kind of cheeses do you like? _____

How frequently do you eat them? _____ Do you eat them with meals, used in cooking, have for snacks? _____ (circle).

Do you eat yogurt? _____ Plain or with fruit? _____ How frequently? _____

Do you eat ice cream? _____ Frozen yogurt? _____ Ice milk? _____ How frequently? _____

Do you drink fruit juices? _____ What kinds? _____ How frequently? _____

Do you eat fresh or canned fruit? _____ What kinds? _____ How frequently? _____

HOW OFTEN DO YOU EAT THE FOLLOWING FOODS:

Vegetables _____ How prepared? _____

Soups _____ Sweet potatoes _____ Potatoes-Baked _____

Mashed _____ Fried _____ Other _____

Eggs _____ How prepared? _____

Liver _____ How prepared? _____

Lamb _____ How prepared?_____

Pork _____ How prepared? _____ Pork products such as bacon, sausage, ham _____

Chicken/Turkey _____ How prepared? _____

Fish _____ How prepared? _____ Beef _____ How prepared? _____

Peanut butter _____Do you eat nuts?_____ If yes, what kind_____

When do you eat them, with snacks and/or meals _____

Peas and/or beans (i.e. lima beans, pinto beans etc.)? _____

White Bread/Rolls _____ Wheat Bread/Rolls _____ Tortillas _____ Biscuits _____

Noodles _____ Rice _____ Cereals _____ What kinds? _____

Coffee _____ Tea _____ Regular Sodas _____ Diet Sodas _____ Alcoholic Bev _____

Punches, Lemonade, Kool-Aid _____ Regular or Sugar Free _____

How much water do you drink per day? _____

HOW FREQUENTLY DO YOU CONSUME THE FOLLOWING?

Candy _____ Pies _____ Cookies _____ Cake _____ Sweet Roll _____ Danish _____

Muffins _____ Sugar _____ Artificial Sweeteners _____ What Type _____

Cooking or Salad Oils _____ Butter or Margarine _____ Gravies _____

Cream _____ Salad Dressing _____ Regular _____ Low Calorie _____

Mayonnaise _____ Regular _____ Light _____

Favorite Foods (List those foods you either eat frequently or would like to at frequently). _____
_____

Do you eat snacks? _____ How frequently? _____ What time of day? _____

List your snack foods? _____

How many meals are eaten at home daily? _____

How often do you eat meals out each week? _____

Circle types of restaurants: Fast Foods, Cafeteria, Select Restaurant Menu

How often do you do the following for lunch (weekly)? Eat at Home _____

Bring lunch from home _____ Eat fast food _____ Cafeteria Food _____

Sit Down, Menu Select Restaurant _____

Do you entertain clients for lunch or dinner? _____ How frequently? _____

What type of restaurant do you usually choose? _____

Do you have a regular exercise regime? _____

What type of exercise and how often? _____

What exercise program could you follow on a regular basis? _____

Do you have any exercise restrictions? _____

_____

_____

To help us in providing a customized meal plan for you, please list below the food and beverages you consumed yesterday. Indicate the amounts of foods and beverages consumed and specify how the food was prepared.

	Food:	Beverage	How prepared:	Amount:
Time that you normally eat Breakfast				
Time that you normally eat Lunch				
Time that you normally eat Dinner				
Time that you normally Snack				

Are there foods that you have given up because you have diabetes that you would like to eat again?

Circle One Yes or No

If so, what favorite food would you like to include?_____

Do you know what foods contain carbohydrates? Circle One Yes or No

If yes, please list some examples. _____

_____

Do you know how much carbohydrate you should eat each meal or snack? Circle One Yes or No

If yes, how much? _____

Do you know the difference between starches and sugars? Circle One Yes or No

If yes, list some examples for each type. _____

_____

What would you like to know about carbohydrate counting and meal planning? _____

_____

What more do you want to know about eating and diabetes? _____

_____

What questions do you have about taking diabetes medications and eating? _____

_____

SOCIAL HISTORY

Does your family support your Diabetes Management goals set by you and your M.D.? Circle One: Yes or No

Please explain _____ .

List any family issues or problems that impact your health or make it difficult for you to achieve your health goals _____

_____ .

Who lives with you? _____ Ages? _____

Who does the grocery shopping? _____

Do you have any trouble obtaining the foods you need to eat to control blood sugars? Circle One: Yes or No

If yes, please explain _____

Who prepares your meals? _____

Do you have trouble obtaining diabetes supplies? Circle One: Yes or No If yes, please explain _____

What meter do you use to check your blood sugars?_____

How often do you check your blood sugars?_____

_____

CULTURAL INFLUENCES

Do you have any dietary restrictions due to cultural or religious beliefs? Circle One: Yes or No

If yes, please explain _____

HEALTH BELIEFS AND ATTITUDES

Are you willing to make changes in your lifestyle to achieve better health? Circle One: Yes or No If no, please explain

_____

_____

HEALTH BEHAVIOR AND GOALS

Do you currently smoke? Circle One: Yes or No
If yes – how long:_____ how many cigarettes a day:_____
If no – when did you stop:_____

Do you have any health habits that you would like to change? Circle One: Yes or No If yes, please explain _____

_____

What do you hope to learn from these classes? _____

BARRIERS TO LEARNING

Do you ever have trouble seeing or reading? Circle One: Yes or No If yes, please explain _____

_____

Do you ever have trouble hearing or understanding what is being said? Circle One: Yes or No If yes, please explain

_____

**********COMPLETE ONLY IF PREGNANT**********
Weight at start of pregnancy _____ Due Date _____

Exercise restrictions _____

Special considerations _____

Weight gain to date _____

**********DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY**********
Height _____ Weight _____

IBW:_____ Patient's Weight Goal: _____ BEE:_____ BMI:_____

Calories needed to maintain current weight: _____

Calories needed to lose weight: _____

Debra F. latimer, R.D., L.D., C.D.E.

LAST NAME	FIRST	INITIAL	ADDRESS	CITY	STATE	ZIP
					TEXAS	

DATE OF BIRTH	MALE FEMALE	CIRCLE MARITAL STATUS	S M D W O	SOCIAL SECURITY NUMBER
DRIVER'S LICENSE	PRIMARY PHONE NUMBER		CELL PHONE NUMBER	E-MAIL ADDRESS
EMPLOYER	WORK ADDRESS		WORK PHONE NUMBER	REFERRING DOCTOR
(1) PRIMARY INSURANCE	INSURANCE ADDRESS		INSURANCE PHONE NUMBER	SUBSCRIBER NAME / DOB
SUBSCRIBER NUMBER	GROUP NUMBER	OFFICE USE:	COPAY AND BENEFITS	
(2) SECONDARY INSURANCE	INSURANCE ADDRESS		INSURANCE PHONE NUMBER	SUBSCRIBER NAME / DOB
SUBSCRIBER NUMBER	GROUP NUMBER	OFFICE USE:	COPAY AND BENEFITS	

PATIENT SIGNATURE ON FILE AUTHORIZATION:

[ ] I authorize the release of any information required in the processing of my claims.

[ ] I authorize my insurance benefits to be paid directly to the health care provider.

X _____ _____

Patient / Guardian Signature Date

OFFICE USE: DX: AUTHORIZATION #

DATE	CPT	UNITS	CHARGE AMT	EXP. AMT	CO-PAY / METHOD