

PREDIABETES INITIAL ASSESSMENT

DIABETES CENTRE

Shading indicates optional completion if recorded elsewhere; i.e., Flow Sheet, Medication Sheet, etc.

Date: _____

Referring/family physician(s):

Accompanied by: no one spouse friend other: _____

FAMILY HISTORY (parents, siblings, children)

Diabetes: Type 1 Type 2 _____
Prediabetes: IFG IGT IFG & IGT _____
 Cardiovascular Disease (CVD) _____
 Obesity Hypertension _____ none

HEALTH STATUS

Medications (Include OTC and supplements) see Medication Sheet none

Recent illness/hospitalization: _____ none

Medical problems (✓ problems only):

hearing: _____ vision: _____ ↑ BP: _____ dyslipidemia: _____
 CVD: _____ stroke: _____ thyroid: _____ cancer: _____
 kidney/urinary tract: _____ bladder: _____ bowel: _____
 arthritis: _____ chronic pain: _____ depression (dx/tx): _____
 previous diagnosis of GDM: _____ other: _____ none

Allergies (food; drug; environmental): N Y (note) _____
_____ none

How often do you see the following?

GP: _____ Specialist: _____

Other: _____ Last appt: _____

Smoking/chewing tobacco: N Y Amount: _____ Quit: _____

Alcohol: N Y Type/amount/freq: _____

Social drugs: N Y Type/freq: _____

HEALTH STATUS (cont)**Women of childbearing age (12-45 years)** n/aBirth control: N Y Method: _____Pregnancy plan: _____ none INSTRUCTED**SOCIAL ASSESSMENT**Support person in place: N Y Comments: _____Lives with: alone spouse/partner other: _____

Occupation: _____

Hours of work: full-time part-time shift (hours): _____ n/a Retired Homemaker other: _____Drug plan (self/spouse): Pharmicare employment plan: _____ Social Assistance other: _____ noneDo you have any financial concerns? N Y _____Your preferred method of learning: listening and talking reading both other: _____

Do you have any religious, family, or cultural practices that may influence how you care for your health? _____

 none

Stressors (If necessary, explore coping mechanisms, support networks, etc.): _____

 none

Does having prediabetes bother you? (fears, past experiences, etc.): _____

How can we help you? _____ not stated**PHYSICAL ACTIVITY** (type/frequency):Aerobic/Walking N Y _____Resistance/Weights N Y _____Other: N Y _____ no specific exercise routine

Recreation/hobbies/work activities (type/frequency): _____

Number of hours a day of screen time (i.e., TV, computer, and/or video games): _____

Barriers to physical activity: _____

 Indicate exercise rating on Flow Sheet INSTRUCTED

NUTRITION**Weight History**

Usual wt: _____

Recent gain or loss (< 6 mos): _____

Goal wt (short/long term): _____

AssessmentPresent wt: _____ Ht or Ht m²: _____

BMI: _____ WC: _____

Acceptable BW range (lbs/kg): _____

Hx of previous diets: N Y Include outcomes/successes: _____Problems with: bowels N Y _____chewing/swallowing N Y _____appetite N Y _____Eating response to: boredom N Y _____stress N Y _____

Restaurant meals (frequency/type): _____

Diet History

Meal/snack times (note weekend changes): _____

Skipped meals: N Y Freq/times: _____Food prepared by: self spouse/partner other: _____Grocery shopping: self spouse/partner other: _____Cooking methods (times/week): fry/deep fry _____ bake/broil/braise/microwave _____Sodium/salt: adds to foods adds in cooking does not useSugar: adds to foods adds in cooking does not useRecent changes in diet: ↓ fats ↓ simple sugars ↓ portions ↑ regular meals
 ↑ fibre other: _____ none**Nutrition/ Food Record** See Questionnaire**Problem Areas Identified** none meal spacing meal irregularity unnecessary snacks high fat poor meal balance inadequate fibre high simple sugar high Na variable CHO intake CHO loading excessive calories excessive protein nutritionally inadequate food group: milk fruit veg protein starch other _____Education/ Material Given: Canada's Food Guide Sample Menu
 Just the Basics other: _____Additional Modifications: fat sodium fibre protein other: _____ INSTRUCTED (see Education Checklist)

