



Pre Diabetes Self-Assessment

Please fill out all of the information on this form and bring it with you to the appointment/group class

Name: _____ Date: _____

Height: _____ Current Weight: _____ Usual Body Weight: _____
Highest Weight: _____ Lowest Weight: _____

List any medication you take.

Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Medication: _____	Dose: _____
Vitamins: _____	Dose: _____
Herbal supplements: _____	Dose: _____

List any Food and/ or Drug allergies:

Medical History (please circle all that apply)

Diabetes High Cholesterol High Blood Pressure Heart Disease CHF
 Sleep Apnea Arthritis Crohn's Disease Celiac Disease Cancer
 Eating Disorder Obesity Polycystic Ovarian Syndrome (PCOS)
 Others _____

Do you experience: ____ morning headaches ____ snoring
 ____ periods of not breathing when sleeping ____ awakening not rested in the morning
 ____ other _____

Exercise

Do you exercise regularly? ____ Yes ____ No
 Type of exercise: _____
 How often do you exercise: _____
 How long do you exercise: _____
 List any limitations with exercise: _____
 Have you ever had an exercise stress test: _____ If so, when: _____

Learning Style

Do you prefer to learn by: ____ reading ____ discussion ____ internet ____ DVD/CD
 ____ hands on training



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Have you had previous diabetes or nutrition education? _____ Yes _____ No

If yes, where and how long ago: _____

Do you have any problems learning about medical conditions because of difficulty understanding written information? _____ No _____ Yes

Are you confident in filling out medical forms independently? _____ No _____ Yes

How often do you have someone help you read hospital materials? _____ Often _____ Never

Intake History

The most important things I want to learn today are:

1. _____

2. _____

3. _____

Do you drink alcohol? _____ No _____ Yes If so, how much? _____

Do you smoke? _____ No _____ Yes If so, how much? _____

Do you have any religious or cultural observations that affect how you eat? _____

If yes, please explain: _____

Do you feel deprived regarding food and meals? _____ No _____ Yes

Do you feel uncomfortable in social situations related to food? _____ No _____ Yes

Do you feel constantly concerned about food and eating? _____ No _____ Yes

Please explain: _____

Who prepares your meals? _____

How is your food usually prepared? _____ Fried _____ Baked _____ Grilled _____ Broiled
_____ Other _____

How many times a week do you eat away from home? _____

_____ Fast Food _____ Restaurant _____ Take out _____ Other

Do you: _____ Skip meals _____ Nibble b/w meals _____ Eat rapidly

_____ Have food cravings _____ Use convenience foods

_____ Eat unplanned meals _____ Other: _____

How much milk or yogurt do you consume in one day? _____

How many vegetables? _____

How many fruits? _____

How much water do you drink in one day? _____

What are your main beverages? _____



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**Please record a “usual” day.
What kind of food? How much food?**

BREAKFAST Time _____	MORNING SNACK Time _____
LUNCH Time _____	AFTERNOON SNACK Time _____
DINNER Time _____	EVENING SNACK Time _____