Memorial Hermann Health System
Diabetes Outpatient Intake Form

Date: _____ Patient Name: _____ DOB: _____ Preferred Language: _____

Race: _____ Last grade completed? _____ E-mail: _____

How do you learn best? ☐ Reading ☐ Hearing ☐ Seeing ☐ Doing ☐ Writing ☐ Other: _____

Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed – Who else in household? _____

Primary Support Person: _____ Who else in the family has Diabetes? _____

Occupation: _____ Time of day you work? _____

Medication Allergies: _____ Diagnosed with Type ____ Diabetes on _____

YES	NO	Patient to complete
☐	☐	Eye Problems:
☐	☐	See eye doctor? Last visit date: _____
☐	☐	Nerve Problems:
☐	☐	Kidney Problems:
☐	☐	Stomach or Bowel Problems:
☐	☐	Foot/Wound Problems:
☐	☐	See Podiatrist? Last visit date: _____
☐	☐	Sexual Dysfunction:
☐	☐	Frequent Infections:
☐	☐	Lung/Breathing Problems:
☐	☐	Heart Problems:
☐	☐	High/Low Blood Pressure:
☐	☐	High Cholesterol:
☐	☐	Stroke Date: _____
☐	☐	Heart Attack Date: _____
☐	☐	Decreased ability to move arms or legs:
☐	☐	Arthritis/Joint Pain:
☐	☐	Requires assistance to walk: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

YES	NO	Patient to complete
☐	☐	Can cross legs to see bottom of feet:
☐	☐	Tobacco Use Type/Amount/Frequency: _____ Quit Date: _____
☐	☐	Alcohol Use Type/Amount/Frequency: _____ Quit Date: _____
☐	☐	Last primary care doctor visit date: _____ Did MD exam feet?
☐	☐	See Dentist? Last visit date: _____
☐	☐	Do you wear medical ID?
☐	☐	Do you exercise regularly? Type: _____ How often: _____ Problems associated with exercise:

Diet: _____

Who shops/cooks: _____

Meals eaten: ☐ Breakfast ☐ Lunch ☐ Dinner

☐ Snacks: _____

Beverage Notes: _____

Do you have any dietary restrictions? ☐ Yes ☐ No

In the last 12 months, the food I bought just didn't last and I didn't have money to buy more: ☐ Often true ☐ Sometimes true ☐ Never true ☐ Decline to answer

In the last 12 months, have you worried your food would run out before you got money to buy more? ☐ Often true ☐ Sometimes true ☐ Never true ☐ Decline to answer

Do you have any food allergies or intolerances? _____

How often do you eat out? _____

Medications: Attach or list (name, dose and frequency)

Memorial Hermann Health System
Diabetes Outpatient Intake Form

Educator to complete

Pt Identifier: ☐State Pt Name: ☐State Date of Birth
Ht.:_____ Wt.: _____ BMI:_____ BP:_____
Labs: Date:_____ Gluc:_____ A1C:_____
Chol:_____ HDL: _____ LDL:_____
TRIG:_____ GFR:_____ OGTT:_____

Hyperglycemia (over 200) ☐ Yes ☐ No ☐ Unsure
How often:_____ Last episode:_____
Hypoglycemia (less than 70) ☐ Yes ☐ No ☐ Unsure
Able to feel symptoms? ☐ Yes ☐ No
How often:_____ Last episode:_____
How do you treat:_____

What is your A1c target? _____

BG history:

What are BG targets? _____

BGM Times? _____
BGM/CGM type:_____

Knows sick day guidelines? ☐ Yes ☐ No

Any Learning barriers?
☐ Visual ☐ Auditory ☐ Literacy ☐ Language
☐ Physical Disability

If previous DM ed when/where: _____
_____

Insulin/DM Injectables:
Insulin Type: _____
When do you take it: _____
Dose: _____
Where do you inject: _____
How do you store insulin:_____

Pregnant: ☐ Yes ☐ No Planning? ☐ Yes ☐ No
Gestation: _____ Due date: _____
Hx of preg complications:

Please list cultural or religious beliefs that may impact your care:

Do you have pain now? ☐ Yes ☐ No
Where is your pain?
Does anything make the pain better?_____
Does anything make the pain worse?_____
How does the pain affect your lifestyle?_____

How would you rate your overall health?
☐ Excellent ☐ Good ☐ Fair ☐ Poor
Does Diabetes cause you stress or distress?

Vaccinations:

Vaccine	Vaccine	Vaccine
☐ Flu	☐ TDAP	☐ Hep B
☐ Covid	☐ Shingles	☐ HPV
☐ Covid Booster	☐ Pneumonia	

Educator Notes

Completed by:

Patient / Guardian Signature	Print Name	Relationship to patient	Date	Time ☐ AM ☐ PM

Staff Signature	Print Name	Title	Date	Time ☐ AM ☐ PM

MEMORIAL HERMANN

Diabetes Outpatient Intake Form