



Walter Reed NMMC Bethesda / Ft. Belvoir
Pediatric Endocrinology
Diabetes Appointment Pre-Assessment

Date: _____
Patient Name: _____
Date of Birth: _____

What concerns do you and your family have about managing life with diabetes?

How do you feel you are doing in managing your/ your child's diabetes?

In what ways is diabetes affecting your everyday life?

What would you like to discuss? (Please check)

- | | |
|--|--|
| <input type="checkbox"/> Nutrition / Carb counting | <input type="checkbox"/> Transition to adult health care |
| <input type="checkbox"/> Anxiety or depressed mood | <input type="checkbox"/> Conception / Future pregnancy |
| <input type="checkbox"/> Hypo/hyperglycemia | <input type="checkbox"/> BG Monitoring |
| <input type="checkbox"/> Driving safely | <input type="checkbox"/> Technology (pumps / CGM) |
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Activity |
| <input type="checkbox"/> Tobacco use | <input type="checkbox"/> Pump back-up plan |
| <input type="checkbox"/> Preparing for college | <input type="checkbox"/> Pre-procedure plan (dental, med/surg) |
| <input type="checkbox"/> Other: _____ | |

Write Your Blood Glucose (BG) and Current Insulin Doses:

On most meters: 7-day BG Average: _____ mg/dL. Number of values (n=): _____

Lantus or Pump Basal Dose(s) & Time(s): _____

Times and Doses for Carb Ratio(s): _____,
Correction Factor(s): _____, BG Target(s): _____

Refills? Glucagon Ketone strips Glucose tabs

Other diabetes refills needed: _____

New email, cell or contact information: _____