



Walter Reed NMMC Bethesda / Ft. Belvoir

Pediatric Endocrinology

**Diabetes Multi-D Appointment Assessment**

Please ask parents or children over 12 years old complete this form.

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Year diagnosed with diabetes: \_\_\_\_\_

How do you and/or your child prefer to learn? Listen, Demonstrate, Read

*Please circle yes or no. If yes, please describe.*

Yes / No Have you been sick since your last visit?

Yes / No Any health concerns today?

Yes / No Any new medications since your last visit?

Yes / No Any food allergies, special diets, or restrictions?

Yes / No Wearing medical alert jewelry?

Yes / No Driving yet? (permit or licensed)

Yes / No Do you feel nervous, anxious, or constantly worried?

Yes / No Do you feel hopeless or have little interest in doing things?

Yes / No Do you feel ashamed of your diagnosis and/or embarrassed?

Last Eye Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_

Flu vaccine: \_\_\_\_\_ Pneumonia vaccine: \_\_\_\_\_

Describe the child's activity level (active play daily, PE, sports, exercise):

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

In what ways is diabetes affecting your everyday life?

Other than diabetes care, are there any other major life changes recently (family separation, change in school, family illnesses)?

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

Meter Brand Name: \_\_\_\_\_

Pump and/or CGM Brand Name: \_\_\_\_\_

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

Times of day of usual BG checks: \_\_\_\_\_

Have you treated a low BG in the past 2 weeks (less than 70mg/dL)? \_\_\_\_\_

What symptoms do you notice during a low? \_\_\_\_\_

What is your low BG (hypoglycemia) treatment? \_\_\_\_\_

Any high BG with ketones in the past 2 weeks (over 300mg/dL with positive ketones)? \_\_\_\_\_

Lantus or Pump Basal Dose(s) & Time(s): \_\_\_\_\_

Times and Doses for Carb Ratios: \_\_\_\_\_

Correction or Sensitivity Factor(s): \_\_\_\_\_

BG Target(s): \_\_\_\_\_

**Refills?**    \_\_ Glucagon                    \_\_ Ketone strips                    \_\_ Glucose tabs

Other Diabetes Refills Needed: \_\_\_\_\_

Preferred pharmacy location for pick-up: \_\_\_\_\_

New Email, Cell, or Contact information: \_\_\_\_\_

Thank you for taking the time to complete this information.

Please return it to the diabetes educator.

WRB Pediatric Subspecialty Clinic