Sarasota County

EMPLOYEE HEALTH and BENEFITS

Employee Health Center
1301 Cattlemen Road, Bldg B
Sarasota, FL 34232
Telephone: (941) 861-6833
Fax: (941) 861-6835

NUTRITION HEALTH/DIABETES ASSESSMENT

NAME: _____ TODAY'S DATE: _____/_____/_____

(Last) (First) (MI)

ADDRESS: _____

MAILING ADDRESS ***(if different from above)***

_____

BENECARD #_____ ***(for DELI members only)***

DATE OF BIRTH: _____/_____/_____AGE: _____ WEIGHT: _____ HEIGHT: _____

PHONE: _____ EMAIL: _____

WORK LOCATION: _____ POSITION: _____

PRIMARY CARE PHYSICIAN _____

ENDOCRINOLOGIST_____

FOOT DOCTOR_____

GASTROENTEROLOGIST_____

OPTHALMOLOGIST (EYE DR.)_____

MEDICAL HISTORY

DO YOU / HAVE YOU EVER HAD (Please check all that apply)

- ☐ Diabetes
  (If yes, fill out diabetes section at end)
- ☐ Pre Diabetes
- ☐ High Blood Pressure
- ☐ Heart Attack / Stroke
- ☐ Arthritis
- ☐ Thyroid Issues (type) _____
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Cancers (type) _____
- ☐ Other _____
- ☐ Sleep Apnea
- ☐ Reflux / Heartburn
- ☐ Back Injury
- ☐ Knee Injury
- ☐ Diverticulitis
- ☐ Diverticulosis
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ Celiac Sprue

Do you feel uncomfortable or bloated after eating? ☐Yes ☐No

Do you experience diarrhea? ☐Yes ☐No

Do you experience constipation? ☐Yes ☐No

Do you use laxatives? ☐Yes ☐No

Has a health care professional ever suggested a specific diet plan for you? ☐Yes ☐No

Please elaborate _____

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LIST ALL MEDICATIONS
(Include prescription and over the counter, as well as any insulin needles, medications or pens)

NAME	DOSAGE

LIST ALL SUPPLEMENTS/VITAMINS

ALLERGIES

_____

_____

PAST SURGERIES

Have you ever been a smoker? ☐Yes ☐No ☐Former How many years? ___ Quit Date: ____

☐cigarettes # packs per day _____ ☐ pipes # bowls per day _____

☐cigars # per day _____ ☐ smokeless tobacco products-quantity:_____

Have you ever drank alcohol? ☐Yes ☐No

Do you drink alcohol now? ☐Yes ☐No If yes, how often? ☐ Daily ☐ Weekly ☐ Infrequent

How many drinks? _____

Do you usually eat breakfast? ☐Yes ☐No Lunch? ☐Yes ☐No Dinner? ☐Yes ☐No

Do you skip meals? ☐Yes ☐No

Do you snack between meals? ☐Yes ☐No

Describe a snack _____

Do you add salt to your foods? ☐Yes ☐No

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How often and how many do you drink of the following?

Diet Soda or Pop	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Regular Soda or Pop	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Coffee	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Tea	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Vegetable Juice	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Power Drinks	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Gatorade	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Smoothies	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Juices	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
Milk	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly

How often do you eat out?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
How often do you eat fast food?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
How often do you eat fried food?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
How often do you eat fish?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
How often do you eat chicken?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly
How often do you eat red meat?	☐ 0	☐ 1-3	☐ 4-7	☐ Daily	☐ Weekly	☐ Monthly

Who lives with you? _____

Who shops at home? _____

Who prepares the meals? _____

What oils do you use when you cook? _____

Do you exercise? ☐Yes ☐No If yes, what activity _____

How often _____ Duration _____

If no, what are your barriers to exercise:_____

Do you have hobbies? _____

What causes you stress? _____

What are some healthy ways you cope with stress? _____

Is there anything else you feel would be helpful to know? _____

_____

_____

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DIABETES ASSESSMENT

What year were you diagnosed? _____

Do you test your blood sugars? ☐Yes ☐No

What type of meter do you have?_____

When do you test? _____

What do they run in the AM? _____

What do they run after eating? _____

What was your last HgA1c? _____

Have you ever received education for your diabetes? ☐Yes ☐No

If so, where? _____

Do you ever experience low blood sugars below 70? ☐Yes ☐No

Do you experience symptoms of low blood sugar such as sweating, dizziness?_____

Who in your family has diabetes? _____

Do you see a special MD for your diabetes (Endocrinologist)? ☐Yes ☐No

When was your last eye exam?_____

When was your last foot exam?_____ Who conducted the exam?_____

Do you examine your own feet? Yes ☐ No☐

Do you cut your own toenails? Yes ☐ No☐

Please make sure to attach/bring 3 days worth of food journals.

If you have questions about completing the food journal; please call Heidi-Jo Kaplan at 861-5239.