THE DIABETES EQUITY PROJECT

Patient Name: ____________________ DOB: _________ Date: _____________

EXAMS AND MEASURES

PLEASE NOTE MOST RECENT RESULTS FIRST

ANTHROPOMETRICS

Date	Ht *(inches)*	Wt *(pounds)*	Waist Circumference *(inches)*	BMI	Date	Ht *(inches)*	Wt *(pounds)*	Waist Circumference *(inches)*	BMI

BLOOD PRESSURE

Date	Result *(systolic/diastolic)*	Date	Result *(systolic/diastolic)*	Date	Result *(systolic/diastolic)*	Date	Result *(systolic/diastolic)*

HEMOGLOBIN A1C

Date	Result	Date	Result	Date	Result	Date	Result

BLOOD GLUCOSE

Date	Measure		Timing		Result
	☐ Blood Glucose		☐ Fasting ☐ Pre-meal	☐ 1 hour Post-Prandial	
			☐ 2 hours Post-Prandial	☐ Random	
			☐ 2 hours Post-Prandial	☐ Random	
Date	**Measure**	**Timing**	**Result**	**Date**	**Measure**
	☐ Blood Glucose		☐ Fasting		☐ Blood Glucose
			☐ 2 hours Post-Prandial		
			☐ 2 hours Post-Prandial		
Date	**Measure**	**Timing**	**Result**	**Date**	**Measure**
	☐ Blood Glucose		☐ Fasting		☐ Blood Glucose
			☐ 2 hours Post-Prandial		
			☐ 2 hours Post-Prandial		
Date	**Measure**	**Timing**	**Result**	**Date**	**Measure**
	☐ Blood Glucose		☐ Fasting		☐ Blood Glucose
			☐ 2 hours Post-Prandial		
			☐ 2 hours Post-Prandial		

TOBACCO

Do you currently smoke?	☐ Yes	☐ No

If "Yes", how much?	☐ <5 per day	☐ ½ pack per day	☐ 1 pack per day	☐ > 1 pack per day	☐ Occasionally
Have you ever been referred to a program to help you stop smoking?				☐ Yes	☐ No
Do you use any other tobacco?					

ALCOHOL				
Patient Drinks Alcohol:			☐ Yes	☐ No
Amount:	☐ Less than 1 drink per day	☐ 1-2 drinks per day	☐ 3 or more drinks per day	☐ Social Occasions

PHYSICAL ACTIVITY						
Do you participate in regular physical activity or exercise?					☐ Yes	☐ No
If "Yes", what type?	☐ Walking	☐ Running	☐ Biking	☐ Swimming		
	☐ Aerobics	☐ Weights	☐ Stretching	☐ Combination	☐ Other	
How long are you active?	☐ < 15 minutes	☐ 16-30 minutes	☐ 31-45 minutes	☐ 46-60 minutes	☐ > 61 minutes	
How often are you active?		☐ <1x per week	☐ 1-2x per week	☐ 3-4x per week	☐ 5-6x per week	☐ >6x per week
How would you rate the activity?		☐ Easy	☐ Moderate	☐ Difficult	☐ Strenuous	
Do you have any physical limitations that prevent you from being physically active or exercising?					☐ Yes	☐ No
If "Yes", please specify:						

SELF FOOT CARE						
Do you examine your feet?					☐ Yes	☐ No
If "Yes", how often?	☐ Daily	☐ Every other day	☐ Occasionally	☐ Rarely		

MEDICATIONS

LIST YOUR PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS, INCLUDING ASPIRIN, VITAMINS, INHALERS, AND HERBAL SUPPLEMENTS

Medication Name:	*How Much Do You Take?*	*When Do You Take the Medication?*

Meal Plan Adherence	☐ 100%	☐ 75%	☐ 50%	☐ 25%	☐ Does not follow

Date	*Microalbumin*

Upload glucose meter results for last 30 days. Print results and upload to DiaWeb.

Medication Attainment Comments: