**Duke Primary Care Diabetes Education Program**
**Pre-Diabetes Patient Information**

Name_____DOB_____Gender___

Have you had prediabetes, diabetes, or gestational diabetes education in the past?
☐Y ☐N If yes, when?_____
List relatives with diabetes _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
How many people live in your home? ____ How are they related to you?_____
Are you currently employed? ☐ Yes ☐No
Occupation? _____ Work hours: _____

## NUTRITION

Do you follow a special diet? ☐Yes ☐No
If so, what are your food restrictions? _____
Do you count carbohydrates? ☐Yes ☐No
What is the hardest part about staying on track with healthy eating?
_____
How many meals do you eat a day? _____How many snacks do you eat a day? ___
Who does the grocery shopping? _____ Who cooks the meals? _____
How many times per week do you eat out? _____
Which type of restaurants? _____
Please provide a sample of your meals and snacks for a typical day:
Time: ____ Meal 1: _____
Time: ____ Snack: _____
Time: ____ Meal 2: _____
Time: ____ Snack: _____
Time: ____ Meal 3: _____
Time: ____ Snack: _____
What do you drink on a regular basis? _____

## PHYSICAL ACTIVITY

Do you exercise? ☐Yes ☐No Type of exercise: _____
How many times a week? _____ for how many minutes? _____
Are you active at work? ☐Yes ☐No Please describe activity: _____

## DIABETES MEDICATION

Do you take any diabetes medications? ☐Yes ☐No
If Yes Name and Dose: _____

## TESTING BLOOD SUGAR

Do you check blood sugar at home? ☐Y ☐N How many times a day?_____
What is the typical range of your blood sugar numbers? _____