Family Health Care Center

Name_____ DOB_____ Chart #_____

Family History: (list family members)

Diabetes_____Cancer_____

Heart Disease_____

Personal History:

Illness	yes	no	Year diagnosed	Controlled? yes or no	Additional info
Diabetes					
High Blood pressure					
High cholesterol					
Poor kidney function					
Arthritis					
Cancer					

Have you ever attended a formal education program about diabetes? Yes | NO

Do you currently smoke/chew/dip ? Yes | NO How much per day?_____

Did you smoke/chew/dip in the past? Yes | NO Year quite_____

Date of last Eye Exam_____

Try to write the times per day/week/month or year the following activities are done:

	Never	Rarely	Sometimes	Frequently
How often do you exercise				
How often do you miss your medications or insulin				
How often do you check your feet				
How often do you visit your provider for diabetes checkups				

What are your concerns today?_____

_____