



Mary Washington Hospital

Thank you for choosing Mary Washington Hospital Diabetes Self-Management Education and Support Services located in the MWHC Medical Pavilion at Cosner's Corner Office Park, 4710 Spotsylvania Parkway, Suite 200, Fredericksburg, VA 22407.

Please arrive 10 minutes prior to your scheduled time if you are unable to fill out your Health History form prior to your appointment.

*We request a minimum of 24-hour notice if you must cancel or reschedule your appointment. Failure to provide 24-hour notice may result in a no-show fee.

As a courtesy, Mary Washington Hospital will bill your insurance company for your diabetes education.

We request that you:

- Bring your completed Health History form (on pages 3–4 of this packet).
- Be prepared to show your insurance card.
- Bring your blood sugar meter and logbook if you currently are checking your blood sugars. You do not need to buy a meter if you do not already have one. We will assist you with that process.
- Please feel free to bring a guest (spouse, friend, family member).
- Remember there is no need to fast before this appointment.

Our health care team of diabetes experts is committed to helping you and your family develop the skills, knowledge, and confidence to control diabetes. Mary Washington Hospital Diabetes Self-Management Education and Support Services has earned the American Diabetes Association Recognition for quality patient education.

If you have any questions, please feel free to contact us at 540.741.2210.

Daniell McKiver
Operations Manager

Our educators:

Stefanie Rekdal, RD, CDCES, CPT
Jody Long, MS, RD, CDCES
Parminder Singh, BSN, RN, CDCES
Courtney Wilkerson, BSN, RN, CDCES
Sarah Whitson, BS, RD, CDCES
Elsa Nicholson, BS, RD

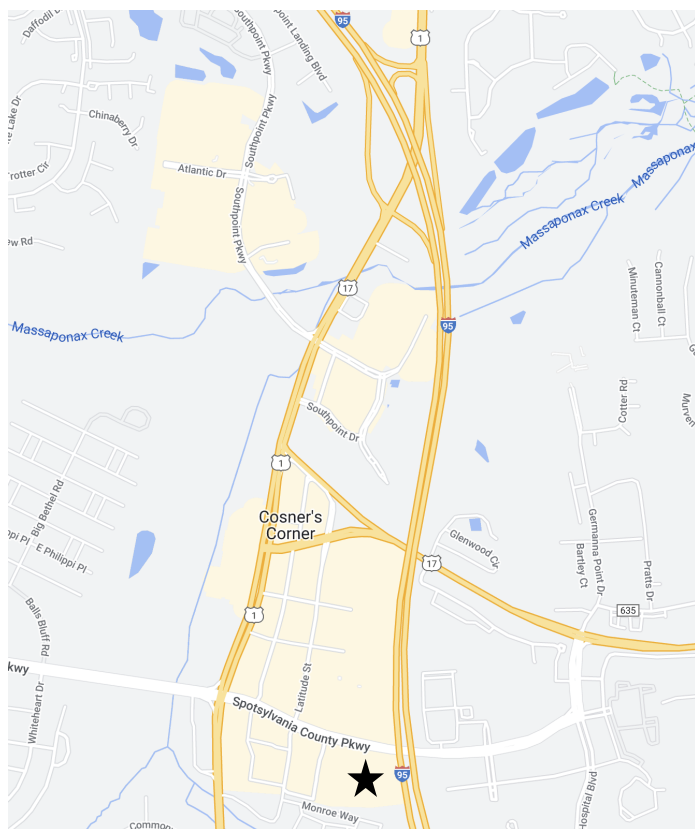
Directions to: Diabetes Management

4710 Spotsylvania Parkway, Suite 200
Fredericksburg, VA, 22407
540.741.2210

From Interstate 95 South, take exit 126-Spotsylvania, Turn right onto Route 1 South. Go approximately 1 mile. Turn left onto Spotsylvania Parkway (there will be a CVS on your right-hand side). Go approximately 0.4 mile. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2nd floor, turning right and right again after elevator

From Interstate 95 North, take exit 126 B onto Rt 1 South. Follow directions listed above.

From Rt VA 2/US 17 (New Post) Take US 17 N towards Rt 1, drive 5 miles. Turn left onto Hospital Boulevard, drive 0.2 miles. Turn right onto Spotsylvania Parkway. Cross over I-95 and make a U-turn. Our location will be on your right-hand side immediately after you pass Jo-Ann Fabrics and Craft store. Look for Cosner's Corner Office Park. Come around to the front of the building. We are located on 2nd floor, turning right and right again after elevator.



Scan me with your phone camera for
Google maps directions.

Name:	Cell Phone:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation:	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D	Gender:
Name of Referring Physician:	Name of Family Physician:	
Are you allergic to any sulfa medications? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Do you have any diagnosed food allergies? <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list:	
Are you aware of the complications that may develop when you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of Diabetes do you have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Unsure When and how were you diagnosed with Diabetes? _____		

PLEASE MARK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol/Triglycerides	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eye/Vision problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last eye exam : _____
Kidney problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental/Mouth problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last dental exam : _____
Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Foot problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you check your feet daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of last foot exam (by physician): _____
Circulation problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Numbness or pain in hands, feet, or legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Difficulty with sexual function	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Gastroparesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment: _____
Have you ever been told you have sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do you use a CPAP/BiPAP machine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If female, do you use contraception?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please list any **other illnesses** not mentioned above: _____

Please list any significant **surgical history**: _____



HAVE YOU EXPERIENCED:

Low blood sugar (70 or below)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospitalization for your diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Name and Dose of Diabetes Medication(s): <input type="checkbox"/> N/A	Side Effects



Patient Label

Do you monitor blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No	Which meter or CGM?	How often/time of day?	Usual readings?
Do you have a family history of diabetes? <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Siblings <input type="checkbox"/> Other	Time lost from work or school in the past year due to diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No How many days? _____		
Do you have any chronic pain ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, where is it located?	Duration of pain?	Any treatment?
How would you rate the pain? 1 2 3 4 5 6 7 8 9 10 (10 is the worst and 1 is the least)			
Intentional Exercise or Activity? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type/Frequency (Ex: walking 30 minutes 3 days/week)		
Highest level of education completed <input type="checkbox"/> Grade School <input type="checkbox"/> High School <input type="checkbox"/> College	Problem with learning? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Describe:	
Have you had any diabetes education before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when and where?	Did friend/family participate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How do you learn best: : <input type="checkbox"/> Listening <input type="checkbox"/> Reading <input type="checkbox"/> Observing <input type="checkbox"/> Doing <input type="checkbox"/> Other _____			
Do you have any difficulty with: <input type="checkbox"/> Hearing <input type="checkbox"/> Reading <input type="checkbox"/> Seeing <input type="checkbox"/> Speaking Please explain or list any other challenges that aren't listed _____			
Do you smoke, vape or chew tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In the past	If yes, what type and how much?	Are you interested in tobacco cessation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol ? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type and how much per week?		
How many people live in your home?	What are their relationships to you?		
Do you use community resources? (example: Health Department, Rappahannock Community Services Board) <input type="checkbox"/> Yes <input type="checkbox"/> No List: _____	Do you get a yearly flu shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a pneumonia shot? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had the Hepatitis B shots? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Within the past 12 months, I/we worried whether my food would run out before I/we got money to buy more. <input type="checkbox"/> Yes <input type="checkbox"/> No Within the past 12 months, the food I/we bought just didn't last and I/we didn't have money to get more. <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any special cultural needs? <input type="checkbox"/> No <input type="checkbox"/> If Yes, please list:			
Do you feel you have adequate support to manage your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
On average, how many hours of sleep do you get? Weekdays _____ Weekends _____			
Check which applies to you: <input type="checkbox"/> Trouble Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Not Feeling Rested			
Why is managing your diabetes important to you?			
What are your biggest challenges in managing your diabetes?			
I want to learn more about: <input type="checkbox"/> Diet <input type="checkbox"/> Exercise <input type="checkbox"/> Stress Management <input type="checkbox"/> Preventing Complications <input type="checkbox"/> Glucose Testing <input type="checkbox"/> Routine Monitoring for Risk Reduction/Target Values <input type="checkbox"/> Other: _____			
FOR OFFICE USE ONLY: The above information has been reviewed and learning needs have been identified. Education Needs/Plan: <input type="checkbox"/> Disease Process <input type="checkbox"/> Nutrition <input type="checkbox"/> Physical Activity <input type="checkbox"/> Using Medications <input type="checkbox"/> Monitoring <input type="checkbox"/> Preventing Acute Complications <input type="checkbox"/> Preventing Chronic Complications <input type="checkbox"/> Behavior Change Strategies <input type="checkbox"/> Risk Reduction Strategies <input type="checkbox"/> Psychosocial Adjustment <input type="checkbox"/> Other: _____			
Diabetes Educator _____		Date _____	
 R N 3 8 9 0		 Mary Washington Healthcare	
Outpatient Diabetes Health History Record		Patient Label	
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