Thank you for choosing the Diabetes & Nutrition Education Center for your nutrition management needs.

**Our office is located at:** MedStar Franklin Square Medical Center  
9000 Franklin Square Drive  
Baltimore, MD 21237  
Main Entrance

Please enter through the main entrance and check in with the front desk. They will direct you to our office once you have registered with them.

Please arrive 15 minutes prior to your appointment time to allow for the registration process.

**You will need to bring:**

- Insurance Card(s), along with photo identification
- Completed Health History information found in this packet.
- Signed Copy of the Attendance Policy included in your packet

For **Diabetes Education Patients**, please bring your completed paperwork, your glucose meter, log book and supplies if you are already testing your blood sugar. This appointment is for education; you may eat and drink prior to your appointment.

For **Bariatric Patients**, please bring completed paperwork, any food logs you have completed, and your class binder.

A support person is welcome to attend the visit if you choose.

**Parking:**

You **may** park at a fee at any of the following locations:

- **Visitor Parking Lot**-off of Franklin Square Drive (Maximum Charge- $8)
- **Entrance 1 Outpatient and Surgical Services** (Maximum Charge- $8)
- **Valet Parking** is available from 9:00am - 5:00pm at Entrance 2 for a $5 fee.
- **Street Parking** is free and available on a first come, first serve basis

If you are unable to keep your appointment please contact the Diabetes & Nutrition Education Center at 443-777-6528. We look forward to working with you.

Thank you,

The Diabetes and Nutrition Education Center Staff
Attendance Policy

Thank you for choosing The Diabetes and Nutrition Center at MedStar Franklin Square Medical Center for your nutrition needs. We are pleased that you and your physician have chosen us to be a part of your treatment process. Please read, fill out and sign where applicable all forms that are attached and bring them with you to your appointment along with your insurance cards and photo identification.

Regular attendance is very important for your treatment. Please call in advance whenever possible to cancel your appointment at 443-777-6528. If you need to call after our normal business hours, please leave a message for our staff informing us of your cancellation.

If you miss two (2) consecutive appointments without calling to cancel or three (3) appointments in a two week period, we will assume you have decided to decline our services and your physician will be notified. Any further appointments will require you to obtain a new physician referral/order.

Additionally, if you are late for your appointments by 15 minutes or more, you risk the chance that we may not be able to accommodate you upon your arrival and your appointment will be rescheduled for a later date and time.

During inclement weather please contact our office before you leave home or work for your appointment to ensure that our office is still operating under our normal hours of operation.

We look forward to working with you.

Date: ____________ Person completing form: ________________ Relationship to patient: ________________
Signature: ____________________________________________
Date: ____________ Staff reviewer signature: ________________________________
Health History Assessment

To complete put an X in the □ and fill in line where appropriate

Do you have any of the following?

☐ Eye Problems: __________________________
☐ Kidney Problems: _______________________
☐ Numbness/Pain: _________________________
☐ Heart Problems: _________________________
☐ Stomach Problems: ______________________
☐ Urinary Incontinence: ___________________

Do you use/have history of:

<table>
<thead>
<tr>
<th>Type?</th>
<th>How Much?</th>
<th>How Long?</th>
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<tbody>
<tr>
<td>Tobacco:</td>
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<td>Alcohol:</td>
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<td>Drugs:</td>
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Are you being treated for:

☐ High blood pressure? □ Yes □ No
☐ High cholesterol? □ Yes □ No
☐ High triglycerides? □ Yes □ No

List any other medical problems not listed above:

________________________________________________________________________

Previous surgeries (please list all):

________________________________________________________________________

Date: _______ Person completing form: __________________ Relationship to patient: _______

Date/Time: ___________ Staff reviewer signature: __________________________

0-32623-6 (09/08)
**Patient Medication Summary**

Any food or drug allergies? □ Yes □ No

Do you wear a medical identification bracelet or necklace? □ □ Yes □ No

Allergy / Reaction: __________________________

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**Please complete the chart below**

<table>
<thead>
<tr>
<th>List all medications, vitamins, minerals, or herbal supplements you are taking.</th>
<th>Reason for taking</th>
<th>How often</th>
<th>Amount you take</th>
</tr>
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<tbody>
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<td>13.</td>
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</tr>
</tbody>
</table>

Date/Time: ______  Person completing form: ________________________________

Relationship to patient: ________________________________________________

Date/Time: ______  Staff Reviewer signature: _______________________________

O-32623-6 (09/08)
To complete, put an "x" in the [ ] where appropriate or fill in the blank line.

I. GENERAL INFORMATION

1. Name: __________________________ Age: __________________

2. Occupation: __________________________ Work Hours: ______________

3. Your Primary Physician’s Name: _______________ Phone Number: ______________

4. How did you hear about our program? ________________

5. How many people live in your household? __________________

6. How do you learn best? [ ] Pictures [ ] Reading [ ] Listening [ ] Demonstration

7. What do you want to learn today? __________________

8. Have you ever been physically abused? [ ] Yes [ ] No

9. Have you ever been touched in a way that makes you uncomfortable? [ ] Yes [ ] No

10. Do you have money concerns that may limit your ability to manage your health? [ ] Yes [ ] No

II. PHYSICAL EXERCISE

1. How active are you during the day? [ ] Mostly sitting [ ] On my feet most of the day

2. Do you exercise? [ ] Yes [ ] No If Yes, what types(s) [ ] Walking [ ] Bicycling [ ] Exercise Machine

[ ] Swimming [ ] Sports [ ] Other

3. How many times a week do you exercise? [ ] 0 [ ] 1-2 [ ] 3-4 [ ] 5-6 [ ] More than 6

4. How many minutes do you exercise at each time? [ ] 0 [ ] 1-10 [ ] 11-15 [ ] 16-29 [ ] More than 30

5. List any limitations for exercise: __________________

6. Do you have any problems with balance? [ ] Yes [ ] No

7. Do you have any problems walking? [ ] Yes [ ] No

8. Do you use assistive devices for mobility? [ ] Yes [ ] No

O-32623-6 (09/08)
III. NUTRITION

1. Height__________ Weight today__________
   Has your weight changed recently? ☐ Yes ☐ No Lost____ pounds Gained ______ pounds

2. How often do you eat/drink the following foods each week?
   Fruit ______ Juice ______ Vegetables ______ Cheese ______ Sweets ______
   Beverages with caffeine______ Beverages with sugar _______ Water ______

3. What type of milk do you drink? ☐ Whole ☐ 2% ☐ 1% ☐ Fat free.
   How many cups of milk do you drink per day? ______ Cups Don’t drink milk______

4. Who does the cooking? __________________________ Who does the grocery shopping? ________________________

5. What type of meat do you buy? ☐ Whatever is on sale ☐ Whatever looks good ☐ Labeled lean or low-fat

6. How is your food usually prepared? ☐ Fried ☐ Baked ☐ Broiled ☐ Grilled
   Do you add fat to your cooking? ☐ Yes ☐ No
   What fats do you add when cooking? ☐ Butter ☐ Oil ☐ Margarine ☐ Ham hocks ☐ Non-stick pan spray

7. How many times during a week do you eat out or carry out from the following:
   Cafeteria-style? _____ Fast food _____ Sit down restaurant? _____ Buffet?_____ Other?_____

8. What best describes your eating habits? (check all that apply)
   ☐ No set meal or snack times ☐ Often skip breakfast ☐ Snack in the morning
   ☐ Snack or “graze” all day long ☐ Usually eat one meal a day ☐ Snack in the afternoon
   ☐ Usually eat three meals a day ☐ Snack before bed

9. List any food allergies or intolerance or special diet needs:__________________________________________

10. How do moods/stress affect your eating?_________________________________________________________
IV. NUTRITION

Please list what you usually eat for meals and snacks on an average day. If you skip a meal or snack, write skip. Please also record the time you eat your meals and snacks.

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Snack</th>
<th>Lunch</th>
<th>Snack</th>
<th>Dinner</th>
<th>Snack</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
<td>Time</td>
</tr>
</tbody>
</table>
V. PREGNANCY (WOMEN COMPLETE, IF PREGNANT)

1. Is this your first pregnancy? □ Yes □ No

2. Number of weeks pregnant:_________ Estimated due date:______________________

3. Weight at start of pregnancy_________ Usual weight when not pregnant:______________________

4. How much weight did you gain with previous pregnancies? ____________________________

5. Did any of your babies weigh more than 9 pounds? ______________________________________

6. I have: □ Gestational Diabetes □ Gestational Diabetes with a previous pregnancy
□ Excessive Weight Gain □ I don’t know
□ Other __________________________

7. If you don’t drink milk, will you take a calcium supplement □ Yes □ No, or eat diet yogurt □ Yes □ No.

Thank you for completing this assessment. Please bring it with you for your first visit.

THE FOLLOWING IS TO BE COMPLETED BY THE ENDOCRINE & DIABETES CENTER STAFF:

VI. EDUCATIONAL NEEDS

□ General Nutrition □ Weight Management
□ Heart Healthy Eating □ Foods for a Healthy Pregnancy
□ Pre-Diabetes □ Other __________________________

_________________________________________  ______________________________
Educator’s Signature                      Date and Time Reviewed with Patient