LAB FOLLOW UP
DIABETES EDUCATION

TEXAS A&M UNIVERSITY
Healthy South Texas

Chronicle ID #: ________________ Name: ______________________________ DOB: ____________ Age: _____

Recommended Calories/Day: _______________ Total Carbohydrate Serving/Day: ________________
Carbohydrate Servings/Day: Breakfast: _________ Lunch: _________ Dinner: ________ Snack: _________
Total Carbohydrate Grams: ________ Ounces of Protein-Meat/Day: _______ Servings of Fat/Day: ________

+Type of glucose meter: _______________ *Pre-exercise blood sugar: ______ *Post-exercise blood sugar: _______

Initial	4-months	8-months
Date: __________________	Date: ____________________	Date: ____________________
+^Height: Feet _____ Inches _____		
+^Waist Circumference: _________ ^Hip Circumference: ___________	Waist Circumference: __________ Hip Circumference: ___________	Waist Circumference: __________ Hip Circumference: ___________
+*Weight: __________________ ^*BMI: ____________________ ^Body Fat %: _______________	Weight ___________________ BMI _____________________ Body Fat % ________________	Weight ___________________ BMI _____________________ Body Fat % ________________
+^Fasting or Non-Fasting (circle one) ^Food intake: _______________ +^Cholesterol: _______________ +^HDL Cholesterol: ___________ +^eGlu: ____________________ +^Triglycerides: _____________ +^Cal LDL: __________________	Fasting or Non-Fasting (circle one) Food intake: _______________ Cholesterol: _______________ HDL Cholesterol: ___________ eGlu: ____________________ Triglycerides: _____________ Cal LDL: __________________	Fasting or Non-Fasting (circle one) Food intake: _______________ Cholesterol: _______________ HDL Cholesterol: ___________ eGlu: ____________________ Triglycerides: _____________ Cal LDL: __________________
+^*Hemoglobin A1c: __________%	Hemoglobin A1c: __________%	Hemoglobin A1c: __________%
+^*Blood Pressure: ____________ ^Heart Rate: ________________	Blood Pressure: _____________ Heart Rate: _________________	Blood Pressure: _____________ Heart Rate:_________________
^Dermal Skin Scan: ___________	Dermal Skin Scan ____________	Dermal Skin Scan ____________
	+Exercise: Type_______________ +How # min per day____________ +Times/week _______________	Exercise: Type_______________ How # min per day____________ Times/week _______________

*Database
^HST Portal
+Chronicle

^Emergency Contact Name: ________________________________ Phone #: ________________Relationship: ________________

+*Physician/Clinic: ______________________________ +Phone #: ___________________+Allergies: _____________________

+*Race: ☐American Indian /Alaskan Native ☐Asian ☐Black/African American ☐White ☐Native Hawaiian/Pacific Islander

^Ethnicity: Are you Hispanic or Latino? ☐Yes ☐No ^+*Gender: ☐Male ☐Female

+^*Type of Diabetes: ☐Pre-diabetes ☐Diabetes, Type1 ☐Diabetes, Type 2 ☐Gestational ☐ Do Not Know ☐Other: ______________

^Relationship Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Separated

^*Do you have a family history of any of the following? ☐Diabetes ☐Heart Disease ☐High Blood Pressure ☐Cancer

+^*Health Insurance: ☐None ☐Medicare ☐Medicaid ☐Medicare/Medicaid ☐Private Insurance, type: _____________________

☐Nueces County Hospital District Card (NCHD) ☐Other____

Initial	4-month	8-month
+Diabetes medications/Other: ☐ None ☐ Yes, (if yes, please list)	Diabetes medications/Other: ☐ None ☐ Yes, (if yes, please list)	Diabetes medications/Other: ☐ None ☐ Yes, (if yes, please list)
+^*How would you rate your general health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor	How would you rate your general health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor	How would you rate your general health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor
	Have you had any health changes since last visit? Yes/No (if yes, describe) ______________________________ ______________________________	Have you had any health changes since last visit? Yes/No (if yes, describe) ______________________________ ______________________________
	+^*Have you had any hospital visit due to diabetes? ☐Yes☐ No	Have you had any hospital visit due to diabetes? ☐Yes☐ No
	+^Have you had any emergency room visits due to diabetes? ☐Yes ☐ No	Have you had any emergency room visits due to diabetes? ☐Yes ☐ No

*Database
^HST Portal
+Chronicle

<table>
<tr><th>Initial</th><th>4-month</th><th>8-month</th></tr>
<tr><td></td><td>+*Type of Goal:
☐ Healthy Eating
☐ Being Active
☐ Taking Medications
☐ Monitoring
☐ Healthy Coping
☐ Problem Solving
☐ Reducing Risks</td><td>Type of Goal:
☐ Healthy Eating
☐ Being Active
☐ Taking Medications
☐ Monitoring
☐ Healthy Coping
☐ Problem Solving
☐ Reducing Risks</td></tr>
<tr><td></td><td>Met Goal:
☐ Never
☐ Occasionally
☐ Half of the time
☐ Most of the time
☐ All the time
☐ New goal ☐ Same goal</td><td>Met Goal:
☐ Never
☐ Occasionally
☐ Half of the time
☐ Most of the time
☐ All the time
☐ New goal ☐ Same goal</td></tr>
<tr><td></td><td>To meet this goal, I will:
____
Min per day? ______________
Days weekly? _____________</td><td>To meet this goal, I will:
____
Min per day? ______________
Days weekly? _____________</td></tr>
<tr><td colspan="3">Over the past 2 weeks, how often have you been bothered by any of the following problems?</td></tr>
<tr><td></td><td>+^Little interest or pleasure doing things
□ Not at all
□ Several days
□ More than ½ of the days
□ Nearly every day</td><td>Little interest or pleasure doing things
□ Not at all
□ Several days
□ More than ½ of the days
□ Nearly every day</td></tr>
<tr><td></td><td>+^Feeling down, depressed, or hopeless
□ Not at all
□ Several days
□ More than ½ of the days
□ Nearly every day</td><td>Feeling down, depressed, or hopeless
□ Not at all
□ Several days
□ More than ½ of the days
□ Nearly every day</td></tr>
<tr><td>^HT #: ________________
Accelerometer #: __________
Date assigned: ___________
Date returned: ___________</td><td>HT #: ________________
Accelerometer # __________
Date assigned: ___________
Date returned: ___________</td><td>HT #: ________________
Accelerometer #: __________
Date assigned: ___________
Date returned: ___________</td></tr>
<tr><td>______________________
CHW Signature
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Date/ Time</td><td>______________________
CHW Signature
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Date/ Time</td><td>______________________
CHW Signature
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Date/ Time</td></tr>
<tr><td>______________________
Educator Signature
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Date/ Time</td><td>______________________
Educator Signature
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Date/ Time</td><td>______________________
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Date/ Time</td></tr>
</table>

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