Diabetes Education Centre

Patient History Form

Please complete the patient history form to the best of your ability. The information provided will assist the educators during your appointments with the centre. Please return the completed form to the centre by mail, email, or in person.

Patient Demographics:

Last Name: _____ First Name: _____ Middle Initial: _____
Date of Birth: (MM/DD/YYY): _____ Health Card Number: _____
Family Physician or Nurse Practitioner Name: _____

Medical History:

What year were you diagnosed with diabetes? _____
Do you have any relatives living with diabetes? ☐ Yes ☐ No
If yes, what is their relationship to you and the type of diabetes: _____

Have you been diagnosed with Celiac disease? ☐ Yes ☐ No If yes, in what year? _____

Please list any current medical conditions, including all allergies and past surgeries, and dates if able:
_____
_____
_____
_____

Medications:
Do you have a private drug plan? ☐ Yes ☐ No
If no, are you covered through any of the following plans:
☐ Ontario Drug Benefits ☐ Ontario Disability Support Program ☐ Trillium ☐ Senior Benefits

Do you use a blister pack for your medications? ☐ Yes ☐ No

Please list all medications you are taking, including vitamins and supplements, below:

Medication Name:	Frequency and time of day	Dose:
Example: Metformin	1x daily, morning	500mg

Updated: August 2021

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Lifestyle/Personal History:

Do you live alone? ☐ Yes ☐ No
Marital Status: ☐ Single ☐ Married/Common Law ☐ Divorced ☐ Widowed ☐ Prefer not to say
Partners Name: _____

Employment Status:
☐ Full time ☐ Part time ☐ Casual/Seasonal ☐ Retired ☐ Unemployed ☐ Other
Occupation: _____
Shifts typically worked: ☐ Days ☐ Afternoons ☐ Evenings ☐ Nights ☐ Rotational

Activity level during work:
☐ Active (manual labour, etc.)
☐ Somewhat Active (some walking/lifting, etc.)
☐ Inactive (desk work, etc.)

Are you in school? ☐ Yes, full time ☐ Yes, part time ☐ No

Recreational Activities:
Do you exercise? ☐ Yes ☐ No If yes, how often: _____

Please list your physical activities (Eg. walking, biking, weight lifting, etc.):
_____
_____
_____

Do you use tobacco or tobacco products? ☐ Yes ☐ No If yes, how often: _____
Do you use marijuana or marijuana products? ☐ Yes ☐ No If yes, how often: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how often: _____

Do you have any questions or concerns related to your diabetes?
_____
_____
_____
_____

What is one of your main focuses for your care?
_____
_____
_____
_____

Signature: _____ Date: _____

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