MedStar Franklin Square Medical Center

Diabetes & Nutrition Education
9000 Franklin Square Dr.-1CA
Baltimore, MD 21237
443-777-6528 PHONE
443-777-8039 FAX
franklinsquare.org

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

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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 advanced 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: _____

Franklin Square Hospital Center
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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: _____ ☐ Heart Problems: _____

☐ Kidney Problems: _____ ☐ Stomach Problems: _____

☐ Numbness/Pain: _____ ☐ Urinary Incontinence: _____

Do you use/have history of:

	Type?	How Much?	How Long?
Tobacco:	_____	_____	_____
Alcohol:	_____	_____	_____
Drugs:	_____	_____	_____

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: _____

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Patient Medication Summary

Any food or drug allergies? ☐ Yes ☐ No
Do you wear a medical identification bracelet or necklace? ☐☐ Yes ☐☐ No
Allergy / Reaction:_____

_____

Please complete the chart below

List all medications, vitamins, minerals, or herbal supplements you are taking.	Reason for taking	How often	Amount you take
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			

Date/Time:_____ Person completing form:_____

Relationship to patient:_____

Date/Time:_____ Staff Reviewer signature:_____

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Bariatric Health History Assessment

To complete, put an "x" in the ☐ where appropriate or fill in the blank line.

I. GENERAL INFORMATION

Date:_____

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

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Bariatric Health History Assessment

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 the 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?_____

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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.

Breakfast	Snack	Lunch	Snack	Dinner	Snack
Time:_____	Time_____	Time_____	Time_____	Time_____	Time_____

Franklin Square Hospital Center

Endocrine and Diabetes Center
9105 Franklin Square Dr., Suite 306
Baltimore, Maryland 21237-3988
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Nutrition Health History Assessment

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
- ☐ Heart Healthy Eating
- ☐ Pre-Diabetes
- ☐ Weight Management
- ☐ Foods for a Healthy Pregnancy
- ☐ Other _____

_____
Educator's Signature

_____
Date and Time Reviewed with Patient