Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention
MAINE DIABETES PREVENTION AND CONTROL PROGRAM: Diabetes Self-Management Training (DSMT)

DSMT-1
(02-2016)

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address
_____		_____	_____ _____

Race ☐ American Indian or Alaskan Native, ☐ Asian, ☐ Black or African-American, ☐ Native Hawaiian or Pacific Islander, ☐ White (Includes Arabs and other Middle Eastern Cultures), ☐ Some Other Race _____, ☐ Two or More Races _____.

Ethnic ☐ Hispanic or Latino, ☐ Non-Hispanic or Latino.

Date of Birth _____
Sex M_____ F _____
Height (Inches) _____
Weight (lbs) _____
Blood Pressure _____/ _____

Year of Onset _____

HbA1c _____
Range _____ --- _____
Date _____

Lipid Profile Date _____
Total Cholesterol _____
HDL-C _____ LDL-C _____
Triglycerides _____

Annual Microalbumin Screen
___ Proteinuria Present
___ Proteinuria Absent/Screen done
Screen Result _____
Date_____
Screen Test Used:
____ Albumin-to-Creatinine Ratio (Spot)
____ 24-hour Collection
____ Timed Collection (e.g. 4hr or Overnight)

Occupation _____
Education _____
Health Insurance
☐ Medicare ☐ MaineCare
☐ Commercial ☐ No Insurance
Learning Style_____
Challenges_____
Cultural Considerations_____

Immunizations
___ Influenza Vaccine in past year
___ Pneumococcal Vaccine

Type/Management of Diabetes

List medications/medical nutrition therapy as appropriate.

☐ Type 1 _____
☐ Type 2 – Diet and Exercise Only
☐ Type 2 – Oral Agent(s):
  ☐ Monotherapy _____
  ☐ Combination Therapy _____
☐ Type 2 – Insulin _____
☐ Type 2 – Insulin & Oral(s)
☐ Other Type: _____
Specify Management _____

Health Care Visits in Past Year

Record number of visits with a provider as appropriate.

_____Dilated Eye Examination
Date of Last Exam _____
_____Dentist
_____Podiatrist
_____OB/GYN
_____Mental Health Professional
_____Doctor Visit
_____Emergency Room Visit
Hospital Admissions
_____ Any Cause
_____ DM-Related
_____ DKA/HHNS

Health Status Assessment: Medical Conditions and Treatment

Check only if applicable. List medication(s)/description as appropriate.

____ Allergies _____
____ Herbal Supplements_____
____ Tobacco Use _____
____ Alcohol Use _____
____ Other substance/product use _____
____ Surgery (Any) _____
____ Eye Disease _____
____ Heart Disease _____
____ Hypertension _____
____ Hyperlipidemia _____
____ Peripheral Vascular Disease _____
____ Respiratory Disease _____
____ Gastrointestinal Disease _____
____ Pancreatitis/Pancreatic Surgery _____
____ Renal Disease _____
____ Genitourinary Disease _____

____ Sexual Dysfunction _____
____ Foot Complication _____
____ Current Deformity/Ulcer _____
____ Amputation, Lower Extremity (Specify) _____
____ Monofilament Test Done _____
____ Loss of Protective Sensation _____
____ Neuropathy _____
____ Other Neurological Disease _____
____ Arthritis/Musculoskeletal Disease _____
____ Other Endocrine disease _____
____ Cancer _____
____ Mental Health/Psychosocial _____
____ Recurring Infection _____
____ Hx DKA/HHNS _____
____ Recurring Hypoglycemia _____
____ Planning/Current Pregnant _____
____ Other _____

_____/_____
Signature of Instructor **Date**