

**Illinois Diabetes Prevention and Control Program
Participant Enrollment Form
ADULT (>18 years)**

Visit Date: _____

ANNUAL VISIT

(PA01)

Name: Last _____ First _____ Middle Initial _____ Phone _____

Address _____

Date of Birth ____/____/____ Gender: Male Female

(PA03)

Race: White African-American Asian/Pacific Islander Native American Other Unknown
Hispanic Origin: Not Hispanic Mexican Puerto Rican Cuban Central/South American
 Other Hispanic Unknown Hispanic Unknown

Females Only: Are you pregnant? Yes No

Current Services: Community Health Center Local Health Department

(PA 15; F5 to add client to program – IDCP – and category – IDCP; F4 to save; F9 to Medicaid/Ins. Information if possible)

Adult Health Visit (PA08)

Weight: _____ pounds _____ ounces Height: _____ feet _____ inches

Blood Pressure: _____

Do you smoke? Yes No Cigarettes per day? _____

Other in Household Smoke? Yes No Smoking Intervention? Yes No

Change in Smoking: No Change Decreased Stopped completely
 Tried but failed Not a Smoker

Do you drink beer, wine or liquor? Yes No

Drinking days per week: _____ Drinks per day: _____

Diabetes Screening (PA33)

Date of Diabetes diagnosis: _____ (Month/Date/Year)

Type of Diabetes: Gestational Type 1 Type 2 Unspecified

Date of last Hemoglobin A1C _____ Result _____ mg/dl

Blood Glucose Testing Method: Fasting Pre-meal Post-meal Result _____ mg/dl

Management Method(s): Insulin type/units/frequency/time of day_____

Oral Medication name/dose/mg/frequency/time of day_____

Nutrition Therapy Exercise Program No management method

Insulin Pump Glucose Monitoring Frequency_____

Assessment (AS01) (DM Assessment Type)

1	Has the patient had diabetes for more than 1 year? (YES/NO) →	
2.	Times in the past year patient was seen by a Health Care Professional? (NUMBER)	
3.	Times in the past year patient received diabetes education? (NUMBER)	
4.	Times in the past year patient received nutrition education from a Registered Dietitian?(#)	
5.	Was the patient hospitalized for any reason in the last year? (YES/NO)	
6.	Was the patient hospitalized for a diabetes related diagnosis in the last year? (YES/NO)	
7.	Times daily the patient's blood glucose is checked? (NUMBER)	
8.	Has the patient ever heard of Glycosylated Hemoglobin or Hemoglobin A1C? (YES/NO)	
9.	Number of times in the past year Glycosylated Hemoglobin was checked? (NUMBER)	
10.	Has patient been diagnosed with high blood pressure? (YES/NO)	
11.	If diagnosed with high blood pressure, is patient receiving treatment? (YES/NO)	
12.	Has the patient had a lipid profile within the last year? (YES/NO)	
13.	Has the patient been diagnosed with high cholesterol? (YES/NO)	
14.	If diagnosed with high cholesterol, is patient receiving treatment? (YES/NO)	
15.	In the past year, has the patient had a dilated eye exam? (YES/NO)	
16.	Time in the past year patient's feet were examined by a health professional? (NUMBER)	
17.	In the past year has patient had a flu shot? (YES/NO)	
18.	Legally blind due to diabetes? (YES/NO)	
19.	If over 21, has your doctor talked to you about taking aspirin on a daily basis? (YES/NO)	
20.	Do you take aspirin everyday? (YES/NO)	

Notes (CM03)

Appropriate Pneumonia Immunization status? Yes No Immunization Date:_____

Diabetes Medication (PA36)

Information collected under the Management Methods for PA33 to complete.

