

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

**Visit Date:** \_\_\_\_\_

**INITIAL VISIT**

(PA01)

Name: Last \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

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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\_\_\_\_\_

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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.

