

PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

19. In the last 12 months, have you: used emergency room services been admitted to a hospital
Was ER visit or hospital admission diabetes related? Y N

20. Do you have any of the following: eye problems kidney problems numbness/tingling/loss of feeling in your feet dental problems high blood pressure high cholesterol sexual problems depression

22. Have you had previous instruction on how to take care of your diabetes? Y N How long ago: _____

22. In your own words, what is diabetes? _____

23. How do you learn best: Listening Reading Observing Doing

24. Do you have any difficulty with: hearing seeing reading speaking
Explain any checked: _____

27. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
Y N Please describe _____

25. Do you use computers: to email look for health and other information

26. Please state whether you agree, are neutral or disagree with the following statements:
I feel good about my general health: agree neutral disagree
My diabetes interferes with other aspects of my life: agree neutral disagree
My level of stress is high: agree neutral disagree
I have some control over whether I get diabetes complications or not: agree neutral disagree
I struggle with making changes in my life to care for my diabetes: agree neutral disagree

27. How do you handle stress? _____

28. What concerns you most about your diabetes? _____

29. What is hardest for you in caring for your diabetes? _____

30. What are your thoughts or feelings about this issue (e.g., frustrated, angry, guilty)? _____

31. What are you most interested in learning from these diabetes education sessions? _____

32. Pregnancy and Fertility:

Are you: Pre-menopausal Menopausal Post-Menopausal N/A

Are you pregnant? Y --When are you expecting? _____

N --Are you planning on becoming pregnant? _____

Have you been pregnant before? Y N Do you have any children? Y --Ages: _____ N

Are you aware of the impact of diabetes on pregnancy? Y N

Are you using birth control? Y --please specify _____ N

Please do not write below this line

CLINICIAN ASSESSMENT SUMMARY: _____

Education Needs/Education Plan: Diabetes disease process Nutritional Management Physical Activity
Using Medications Monitoring Preventing Acute Complications Preventing Chronic Complications
Behavior Change Strategies Risk Reduction Strategies Psychosocial adjustment

Date: _____ Clinician Signature: _____