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| **PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT** | | | | |
| Name: Date: | | | | |
| Date of Birth: / / Age: Gender: |  | F |  | M |
| Ethnic Background: White/Caucasian Black/A-A Hispanic Native American Middle-eastern | | | | |
| What is your language preference: English Other  Address:  Street City ST Zip | | | | |
| Phone: Home ( \_)\_ Work: ( ) Mobile: ( ) | | | | |
| 1. What type of diabetes do you have? Type 1 Type 2 Pre-diabetes GDM Don’t Know | | | | |
| 2. Year/Age of Diabetes Diagnoses: /\_ List relatives with diabetes: | | | | |
| 3. Do you take diabetes medications? Y (check all that apply below) N  Diabetes pills Insulin injections Byetta injections Symlin injections  Combination of pills and injections  About how often do you miss taking your medication as prescribed? | | | | |
| 4. Do you have other health problems? Y N  Please list other medical conditions: | | | | |
| 5. Do you take other medications? Y N Please list other medications:\_ | | | | |
| 6. What is the last grade of school you have completed? | | | | |
| 7. Are you currently employed? Y N What is your occupation? | | | | |
| 8. Marital Status: Single Married Divorced Widowed How many people live in your household? | | | | |
| 9. How are they related to you? | | | | |
| 10. From whom do you get support for your diabetes? Family Co-workers Healthcare providers  Support group No-one | | | | |
| 11. Do you have a meal plan for diabetes? Y N If yes, please describe:  About how often do you use this meal plan? Never Seldom Sometimes Usually Always  Do you read and use food labels as a dietary guide? Y N  Do you have any diet restrictions: Salt Fat Fluid None Other  Give a sample of your meals for a typical day: Time: Breakfast:\_  Time: Lunch: Time: Dinner:  Time: Snack: Time: Snack: | | | | |
| 12. Do you: do your own food shopping? Y N Cook your own meals? Y N  How often do you eat out? | | | | |
| 13. Do you drink alcohol? Y N Type: How many per day per week occasionally | | | | |
| 21. Do you use tobacco: cigarette pipe cigar chewing none quit --how long ago | | | | |
| 14. Do you exercise regularly? Y N Type: How Often:  My exercise routine is: easy moderately intense very intense | | | | |
| 15. Do you check your blood sugars? Y N Blood sugar range: to  How often: Once a day 2 or more/day 1 or more/Week Occasionally  When: Before breakfast 2 hours after meals Before bedtime  What is your target blood sugar range? | | | | |
| 16. In the last month, how often have you had a low blood sugar reaction: Never Once  One or more times/week  What are your symptoms? How do you treat your low blood sugar? | | | | |
| 17. Can you tell when your blood sugar is too high? Y N  What do you do when your sugar is high? | | | | |
| 18. Check any of the following tests/procedures you have had in the last 12 months:  dilated eye exam urine test for protein foot exam--self --healthcare professional dental exam blood pressure weight cholesterol HgA1c flu shot pneumonia shot | | | | |

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| **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: | | | | | | |

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