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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) NDiabetes pills Insulin injections Byetta injections Symlin injectionsCombination of pills and injectionsAbout how often do you miss taking your medication as prescribed? |
| 4. Do you have other health problems? Y NPlease 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 providersSupport 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 AlwaysDo you read and use food labels as a dietary guide? Y NDo you have any diet restrictions: Salt Fat Fluid None OtherGive 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 NHow 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: toHow often: Once a day 2 or more/day 1 or more/Week OccasionallyWhen: Before breakfast 2 hours after meals Before bedtimeWhat is your target blood sugar range? |
| 16. In the last month, how often have you had a low blood sugar reaction: Never OnceOne or more times/weekWhat are your symptoms? How do you treat your low blood sugar?  |
| 17. Can you tell when your blood sugar is too high? Y NWhat 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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| 19. In the last 12 months, have you: used emergency room services been admitted to a hospitalWas 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 speakingExplain 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 disagreeMy diabetes interferes with other aspects of my life: agree neutral disagreeMy level of stress is high: agree neutral disagreeI have some control over whether I get diabetes complications or not: agree neutral disagreeI 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 adjustmentDate: Clinician Signature:  |

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