Diabetes & Nutrition Teaching Center
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Patient Diabetes Self-Assessment

To be completed by patient ___________________________ **Date: _________________________________**
Signature **Doctor who referred you: ________________**
Diabetes Doctor: _______________________

1. Demographics:

Name____
Address ____
Phone ________________________ Work Phone ______________________Email______________________________

Sex:
___ male
___ female

Marital Status:
___ Single ___ Married
___ Divorced ___ Widow

Race:
___ Caucasian ___ African American
___ Hispanic ___ Asian
___ Other ___ American Indian/Eskimo

Age: ___________ Birthdate: _____________________

What kind of work do you do: ______________________ Hours worked: __________ Shift worked: _________

Retired:
___ Yes
___ No

Religion:
___ Catholic ___ Protestant
___ Jewish ___ Other

Previous Diabetes Education:
___ Yes When: ____________________
___ No Where: ____________________

Do you live with anyone? ___ Yes ___ No If yes, who: ____
Do you have a person who helps you manage your diabetes? ___ Yes ___ No
If yes, list: ____

Besides yourself, does anyone in your home have diabetes? ___ Yes ___ No

What grade of school did you complete? ________________________________
Do you have enough money to buy your food? ___ Yes ___ No Diabetes Supplies? ___ Yes ___ No

2. Medical and Diabetes History

Do you have any barriers to learning/special education needs? ___ Yes ___ No
If yes: ___ Visual ___ Hearing ___Literacy ____ Other __________________________________

Do you have:
___ Yes ___ No High Blood Pressure
___ Yes ___ No Heart Disease
___ Yes ___ No Kidney Disease
___ Yes ___ No Numbness, pain, burning
___ Yes ___ No Eye Problems

___ Yes ___ No Foot Problems
___ Yes ___ No Excess Weight
___ Yes ___ No Chronic Constipation
___ Yes ___ No Frequent Urination
___ Yes ___ No Get Infections Often
Other: (list) ______________________________

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List any surgeries: ____

When were you first told your blood sugars were high? (year or date) ______________________________

Do you have: Type 1, Type 2, or Gestational diabetes? ____

What pills or shots do you take for your diabetes? ____
Pills: name/dose ______________________ When do you take? __________________________
Insulin: name/dose _____________________ When do you take? __________________________

List all other pills you take: ____
Do you take vitamin/mineral pills? ___ Yes ___ No If yes, list: __________________________________

Do you have any allergies? ___ Yes ___ No If yes, list: ____

Do you check your blood sugars at home? ___ Yes ____ No If yes:
When do you test _____________________ How often each day ___________________________
Name of meter ________________ Do you keep a record of your blood sugar results? ___ Yes ___ No
What range are your blood sugars at home?
__________before breakfast ________before meals _______ after meals _________bedtime

Do you know what your last glycosolated hemoglobin (HbA1c) was? ________________________________

How often are your blood sugars over 240? _______________________

Do you have blood sugars less than 70? ____ Yes _______ No
What time of day? ________ How often? ___________ How do you treat them? ___________________

Do you check your urine for ketones? ___ Yes ___ No If yes, when ________________________

Do you adjust your insulin shots or sugar pills on you own? ___ Yes ___ No _________Does not apply

Do you take your diabetes medicines every day? ____ Yes ____ No _________ Does not apply

3. Activity

Exercise: ___ Never ___ 1-2 times/week ___ 3-4 times/week ___ 5-7 times/week
Time of day you exercise _______________ How Long ________________minutes
Type: ___Walk ______Swim _____Bike ______ Jog ___ Aerobics ______Other _____________

How does exercise change blood sugars? ____

4. Self Care
How often do you check your feet? ____ daily ____ weekly ____ don't check ____ other _______________

Do you go barefoot? ___ Yes ___ No

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Do you put anything on you feet (like lotion, alcohol)? ____

How often do you see your doctor for your diabetes? ____

Last dilated eye exam (Dr. puts drops in your eyes)? ____

Smoke/chew ___Yes ___ No Alcohol ___ Yes ___ No ___ Quit
If yes, how much/types ____

When you are sick, so you: take your diabetes pills/shots __ Yes ___ No, check your blood-

sugars more often ___ Yes ___ No

What do you eat when you are sick if you can't eat solid foods? ____________________________

Have you been in the hospital or Emergency Room in the past 12 months? ___ Yes ___ No
Reason(s): ____

On a scale of 1 to 10, how much stress do you have in your life? (1 = least & 10 = most) _______
Reason(s): ____

What are your feelings about having diabetes? ____

What concerns you most about your diabetes? ____

What areas of diabetes would you like to learn more about? __________________________________

How would you rate your health? ____ Poor ____ Fair ____Good ____ Very Good

May we use the results of your HbA1c test in studying and/or telling others about the quality of our service?
(Your name will not be released.)
____ Yes ____ No

5. <u>Gestational/Pregnancy – complete this section only if you are pregnant</u>

Due Date: __________________________ Pre-pregnancy weight ________________

How many weeks pregnant are you? ________________

Any other problems with this pregnancy? ____

Did you have diabetes with other pregnancies? ____ Yes ____ No

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6. Nutrition

Height __________ Weight ___________ What do you want to weigh? ______________

Have you lost/gained in weight in the last 6 months? ___ Yes ___ No
How much have you lost? ___________ (or) How much have you gained? _____________

Have you ever been on a diabetic diet before? ___ Yes ___ No
If yes, calorie level _____________

Do you follow it ___ Yes ___ No

Have you ever used exchange list? ___ Yes ___ No

Do you change your diet for other reasons? ___ sugar ___ salt ___ fat ___ protein
If other, explain: ____
Do you have any food allergies or foods you avoid that don't agree with you ______________________
If yes, list the foods: ____
Do you skip meals? _____________ If yes, which meals: ____________________________________

Do you eat meals/snacks at the same time every day? ___ Yes ___ No

Do you eat differently on the weekends? ___ Yes ___ No
If yes, explain: ____
Who shops for your food? ____

Do you drink milk? ___ Yes ___ No If yes, which meals? ____________________________________
What kind? ___ Skim ___1% ___2% ___ whole

How often do you eat out (meals per week): ___ 0-1 ___ 2-4 ___ 5-8 ___ more than 9
What type of places do you eat out? ____

Please list any foods you don't like: ____

Do you have any problems with:

___ Chewing ___ Swallowing ___ Heartburn/indigestion ___ Vomiting ___ Binge eating

___ Laxative abuse ___ Constipation ___ Diarrhea ___ often feels bloated after eating

___ Not eating enough

Do you salt your food? ___ Yes ___ No