Diabetes Self-Management Assessment Form

Please answer the questions by marking appropriate boxes or writing in accurate information in provided spaces. If you are unsure about how to answer a question, please give the best answer you can.

DEMOGRAPHIC INFORMATION **Name:** ____

Today's date: ______________ **What is your age?** __________ **What is your Gender?** ❑ Female ❑ Male

What is your Race/Ethnicity? *(mark all that apply)*

- ❑ Black or African American
- ❑ American Indian or Alaska Native
- ❑ White or Caucasian
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Guamanian or Chamorro
- ❑ Other______________________________
- ❑ Asian
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Middle Eastern
- ❑ Chinese
- ❑ Japanese
- ❑ Vietnamese
- ❑ Samoan

Are you Hispanic (Latino, Mexican, Spanish)? ❑ Yes ❑ No

Education *(mark highest level completed)*

❑ Elementary school ❑ Some high school ❑ High school degree
❑ Some college ❑ College degree ❑ Postgraduate

What is your Occupation? *(mark only one)*

❑ Clerical ❑ Homemaker ❑ Sales ❑ Professional/Managerial
❑ Skilled Labor ❑ Other Labor ❑ Student ❑ Unemployed
❑ Retired ❑ Other

Do you have any physical limitations? *(mark all that apply)*

❑ Hearing problems ❑ Vision loss (not corrected by glasses or contacts)
❑ Problems with use of hands

What is your primary language?

❑ English ❑ Spanish ❑ Other, please list: ______________________________
____

HEALTH HISTORY

General Health Issues: *(check all that apply and explain)*

- ❑ high blood pressure
- ❑ heart disease
- ❑ stroke
- ❑ high cholesterol
- ❑ thyroid disease
- ❑ problems with sexual function *(explain)* ______________ ____
- ❑ kidney/bladder problems *(explain)* ______________ ____
- ❑ asthma
- ❑ shortness of breath *(explain)* __________________
- ❑ sleep apnea
- ❑ eye or vision problems *(explain)* ________________
- ❑ numbness/pain/tingling of hands/feet *(explain)* ______ ____
- ❑ foot problems *(explain)*__________________________
- ❑ frequent nausea, vomiting, constipation, diarrhea ____
- ❑ other health problems ___________________________
- ❑ list any surgeries in last 5 years ________________ ____

As health care providers, we are concerned about the safety of our patients so we ask every patient:

Do you feel safe at home? ❑ No ❑ Yes
Do you feel safe in your neighborhood? ❑ No ❑ Yes *(If no, you may discuss this with the diabetes educator)*

Women's Health: *(check if applies)*

❑ pregnant ❑ planning pregnancy ❑ history of gestational diabetes
❑ using contraception ❑ menopausal ❑ other

PATIENT IDENTIFICATION

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2DIABRE

DIABETES HEALTH STATUS

What year were you told you had diabetes? ___________________

Have you attended a diabetes education program? ❑ No ❑ Yes

What infections have you had within the last 3 months *(mark all that apply)*

❑ Head, throat, chest ❑ Wound ❑ Vaginal (yeast) ❑ Bladder ❑ None

Do you have family history of diabetes? ❑ No ❑ Yes

ACTIVITY:

What type of exercise do you do? ❑ walk ❑ bike ❑ aerobic machine ❑ swim ❑ sports ❑ active job

❑ other ____

How often do you currently exercise? *(times/week)* ❑ 0 ❑ 1-2 ❑ 3-4 ❑ 5-6 ❑ > 6

How long? *(minutes/day)* ❑ 0 ❑ 1-15 ❑ 16-30 ❑ 31-45 ❑ 46-60 ❑ >60

Has your doctor advised you to restrict your activities? ❑ no ❑ yes Explain: ______________________

EATING HISTORY

Usual time you get up ______________________ go to bed ______________________

Meal times: breakfast ________________ lunch ________________ dinner ________________

a.m. snack ________________ afternoon snack ________________ p.m. snack ________________

Do you drink alcohol? ❑ No ❑ Yes *type:* ❑ beer ❑ wine ❑ mixed drink

how often: ❑ < once a week ❑ once a week ❑ once a day ❑ 2 or more drinks every day

Food preferences: ❑ vegetarian ____________________ ❑ other ____________________

Food Allergies: ____

MEDICATIONS

Drug allergies: ❑ No ❑ Yes *(please list)* ____

MEDICATION AND DOSE (include prescriptions, vitamins, herbals, and over the counter)	**TIMES TAKEN**	**DATE STARTED**
Aspirin _______mg ❑ Yes ❑ No		

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MONITORING:

Are you testing your blood sugars at home? ❑ no ❑ yes

Name of meter ____________________

How many days a **week** do you usually test? ❑ none ❑ 1-2 days/week ❑ 3-5 days/week ❑ daily ❑ occasionally

How many times a **day** do you usually test? ❑ 1-2 times/day ❑ 3-4 times/day ❑ more than 4

What blood sugar range do you try to achieve? ____________________

Do you have low blood sugar reactions? ❑ no ❑ yes symptoms ____________________

If so, what time of day? ❑ morning ❑ afternoon ❑ evening ❑ overnight ❑ varies

# of times per week: ❑ 0 ❑ 1-2 ❑ 3-4 ❑ > 4

Do you carry a sugar source? ❑ no ❑ yes ____________________(describe)

Do you wear diabetes identification? ❑ no ❑ yes ____________________ (describe)

What was the result of your last Hemoglobin A1C test? __________% Date: ______________ ❑ Unsure

WELLNESS / LIFESTYLE:

Tobacco use: type: cigarettes / cigars / tobacco ❑ never ❑ quit (year ________) ❑ yes (amount/day _______)

In last 12 months: # times you have seen primary MD ____________________

times you have seen specialist MD ____________________

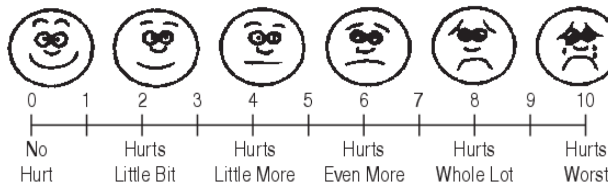
Indicate date of:

Last dilated eye exam ____________________ Flu shot ____________________

Last foot exam ____________________ Pneumonia vaccine ____________________

Do you have any pain because of your diabetes today? ❑ No ❑ Yes If Yes, where is the pain? __________

If yes, please rank your pain on a scale of:



List any medications or treatment you use to take care of the pain ____________________

Is your pain relieved with medication or other treatment? ❑ No ❑ Yes

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How often do you need to have someone help you with instructions, pamphlets, or other written material from your doctor or pharmacy?

❑ never ❑ rarely ❑ sometimes ❑ often ❑ always

LIVING WITH DIABETES

a. **Please tell us how you feel about your diabetes** *(mark one answer for each question)*

	A Lot	Some	A Little	Not at All
How sure are you that you can manage your diabetes?	❑	❑	❑	❑
How much do you feel your family/friends support your efforts for diabetes control?	❑	❑	❑	❑
How much does your medical team help with your diabetes?	❑	❑	❑	❑
How much does diabetes interfere with your job, school, or daily activities?	❑	❑	❑	❑
How much does your diabetes seem out of control?	❑	❑	❑	❑
How much are you afraid you will get complications?	❑	❑	❑	❑
How often do you feel overwhelmed by your diabetes?	❑	❑	❑	❑
How much does your diabetes interfere with sexual function?	❑	❑	❑	❑
During the past 2 weeks:				
Have you often been bothered by feeling down, depressed, or hopeless?	❑	❑	❑	❑
Have you often been bothered by little interest or pleasure in doing things?	❑	❑	❑	❑

To help us focus on diabetes issues which concern you most, please identify any issues that are especially important to you:

❑ Eating healthfully and following my food plan

❑ Testing my blood sugar regularly

❑ Balancing stress

❑ Preventing complications

❑ Becoming and staying physically active

❑ Taking diabetes medication as prescribed, if any

❑ Seeking support when I need it

❑ Problem solving: dealing with challenges associated with diabetes

❑ Others ______________________________

Is it difficult for you to pay for diabetes care? ❑ no ❑ yes *(explain)* ______________________

Are you aware of diabetes community resources? ❑ no ❑ yes

Participant Signature ______________________________ Date ______________

Educator Comments:

Date reviewed: ______________________ Educator Signature: ______________________

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