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Diabetes Self-Management Assessment Form | **Inova Center for Wellness and Metabolic Health**

For Educator Use:

Ht: _____ Wt: _____lbs.

Name: _____ **Today's Date:** _____

Primary Language: □ English □ Other_____

Occupation:_____ Education/Last Grade Attended _____

Do you have any Allergies to food or medicine? □ Yes □ No If yes, please list: _____

When were you told that you had diabetes?_____

Do you have any financial worries regarding Diabetes care? □ Yes □ No

Learning

Do you have any physical conditions that will affect diabetes care or learning? □ Yes □ No

If yes, please list: _____

Have you been to a diabetes program or had diabetes education? □ Yes □ No

If yes, When_____ Where_____

What is most important to you to learn about taking care of diabetes?

_____

Self Care Behaviors

Do you have a history of tobacco use? □ Yes □ No Quit date:_____ Do you currently smoke tobacco? □ Yes □ No

History of tobacco use (cigarette, cigar, pipe, chew, smokeless)?_____

How much tobacco do you smoke a Day? □ Less than 5 □ ½ pack □ whole pack □ more than a pack

Do you drink Alcohol? □ Yes □ No

How much do you drink? □ A drink a day □ 2 drinks a day □ more than 3 drinks a day □ only socially

Medication

Medication and Dosage: Please include prescription, vitamins, herbals & over the counter	Times taken	Date Started

Other Medical History

□ Eyes: (eyes disease, blindness, or surgeries)	□ Intestines/Digestion: (Chronic diarrhea, constipation, ulcers, and reflux)
□ Kidney: (renal failure, dialysis)	□ Arms/Legs/Feet: (numbness, tingling, difficulty moving, sores, wounds, infection)
□ Heart Disease/Blood pressure (High cholesterol, congestive heart disease, heart attack, heart abnormalities, high blood pressure, history stroke, blood clots)	□ Other (Pain or anything that is not listed)

Immunization History

Have you had the flu shot: □ Yes □ No Date:_____

Have you had the pneumonia vaccination: □ Yes □ No Date:_____

Physical Activity

What type of physical activity do you participate in: □ None □ Walking □ Biking □ Aerobic machine

□ Swimming □ Active Job □ Other:_____

Frequency per week? □0 □ 1-2 days □ 3-4 days □ 5-6 days □ 7 days

Duration of time? □0 □ 1-15minutes □ 16-30 minutes □ 31-45 minutes □ more than 60 minutes

Blood Glucose Monitoring

Do you check your blood glucose? □ Yes □ No What brand of meter do you use? _____

Testing frequency (days/week): □ 0 □1-2 □3-5 □daily Testing frequency (times/day): □ 0 □1-2 □3-4 □more than 4

Problem Solving/Risk Reduction

Have you had any low blood sugars (under 70 mg/dl) the past two weeks? □ Yes □ No

Do you carry a source of fast acting carb? □ No □ Yes **If so, describe:**_____

Have you had an annual foot exam: □ Yes □ No Have you had an annual eye exam: □ Yes □ No

Patient Self-Assessment

Do you have pain related to diabetes: □ Yes □ No Rate (0 is low -10 is high)_____

Do you have any cultural or religious dietary practices? □ Yes □ No Please Specify: _____

Have there been any changes in your eating habits? □ Yes □ No Please Specify:_____

List any special food considerations in developing a meal plan for you:

_____

Over the past 2 weeks, have you often been bothered by:

- How often does taking care of your diabetes interfere with your lifestyle: □ Not at all □ A little □ Some □ A Lot
- Have you felt sad or depressed about having diabetes: □ Not at all □ A little □ Some □ A Lot

Do you carry identification that states you have diabetes? □ Yes □ No

Participants Signature:_____ Date _____

Educator Signature:_____Date_____