Pediatric 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

Are there other care givers in your home? ❑ Yes ❑ No Explain: _____

Education

What grade are you in? _____ Day care/after school care? ❑ Yes ❑ No _____

Which school do you attend? _____

How do you learn best? ❑ reading ❑ class ❑ films ❑ computer ❑ participation/demonstration

Do you have a job? ❑ Yes ❑ No

Type of work: _____ Typical hours: _____

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: _____

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
- ❑ Managing school schedule and educating staff
- ❑ 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

HEALTH HISTORY

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

- ☐ high blood pressure
- ☐ heart disease
- ☐ frequent infections
- ☐ high cholesterol
- ☐ thyroid disease
- ☐ ADD/ADHD
- ☐ frequent nausea, vomiting, constipation, diarrhea _____
- ☐ other health problems _____
- ☐ asthma
- ☐ mental health _____
- ☐ sleep apnea
- ☐ eye or vision problems *(explain)* _____
- ☐ numbness/pain/tingling of hands/feet *(explain)* _____
- ☐ Gum disease ☐ Celiac disease ☐ Learning disability
- ☐ foot problems *(explain)* _____
- ☐ kidney/bladder problems *(explain)* _____

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

☐ head, throat, chest ☐ wound ☐ vaginal (yeast) ☐ bladder ☐ none

DIABETES HEALTH STATUS

What year were you told you had diabetes? _____

Is your diabetes: ☐ Type 1 ☐ Type 2 ☐ not sure

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

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

How many times have you been seen in the emergency room? _____

How many times have you been in the hospital? _____ Reason? _____

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

Do you have PE at school? ☐ Yes ☐ No What time: _____

Do you adjust insulin and/or diet for activity? ☐ Yes ☐ No If yes, how: _____

EATING HISTORY: school days:

Usual time you get up _____ go to bed _____

Meal times: breakfast _____ lunch _____ dinner _____

a.m. snack _____ afternoon snack _____ p.m. snack _____

EATING HISTORY: weekend days:

Usual time you get up _____ go to bed _____

Meal times: breakfast _____ lunch _____ dinner _____

a.m. snack _____ afternoon snack _____ p.m. snack _____

In the past month, have you: ❑ lost weight ❑ gained weight ❑ # lbs lost/gained: _____ ❑ No change

If you lost weight, was it: ❑ intentional ❑ unintentional

Have you ever adjusted your insulin to influence your body weight? ❑ Yes ❑ No

Do you have any diet restrictions? (allergies/intolerances, religious, vegetarian) _____

Is it hard to control what you eat? ❑ Yes ❑ No

Do you skip meals: ❑ Yes ❑ No

How many times per week do you eat out? ❑ 0-1 ❑ 2-4 ❑ 5-8 ❑ daily

Do you eat school lunch? ❑ Yes ❑ No ❑ sometimes

How often do you eat the following foods:

Fruit	❑ never	❑ rarely	❑ sometimes	❑ often
Vegetable	❑ never	❑ rarely	❑ sometimes	❑ often
Milk	❑ never	❑ rarely	❑ sometimes	❑ often
Soda/fruit drinks	❑ never	❑ rarely	❑ sometimes	❑ often
Water	❑ never	❑ rarely	❑ sometimes	❑ often

MEDICATIONS

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

MEDICATION AND DOSE (Include prescriptions, vitamins, herbals, and over the counter)	TIMES TAKEN	DATE STARTED
Glucagon ❑ Yes ❑ No		

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 ❑ Other_____

Where do you test your sugar at school? _____

What do you carry to treat a low sugar? _____(describe)

Have you ever needed help to treat a low sugar?

Explain:_____

_____

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

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

WELLNESS / LIFESTYLE:

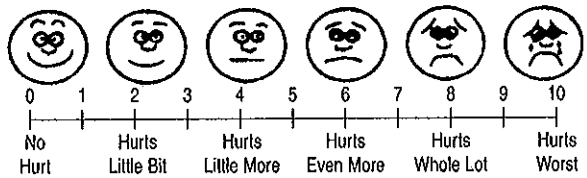
Tobacco use: type: cigarettes / cigars / tobacco ❑ never ❑ quit (year_____) ❑ yes (amount/day_____)
Recreational drug use: ❑ never ❑ quit (year_____) ❑ yes (amount/day_____)
Alcohol use: ❑ never ❑ quit (year_____) ❑ yes (amount/day_____)
Indicate date of:
Last dilated eye exam_____ Flu shot_____
Last foot exam_____

Sexual Activity: *(check if applies)*

❑ pregnant ❑ using contraception ❑ sexually active

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

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

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

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

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 diabetes interfere with your relationships?	❑	❑	❑	❑
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?	❑	❑	❑	❑

Patient/Caregiver Signature _____Date_____

Date reviewed:_____Educator Signature:_____

PATIENT IDENTIFICATION

INOVA HEALTH SYSTEM

PEDIATRIC DIABETES SELF-MANAGEMENT ASSESSMENT

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