PARTICIPANT SELF-ASSESSMENT OF DIABETES MANAGEMENT

Name: _____ Date: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female

Ethnic Background: ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Middle Eastern

Address: _____ City: _____ State: _____ Zip: _____

Phone: *Home* ( ) _____ *Work* ( ) _____ *Cell* ( ) _____

What is your language preference: ☐ English ☐ Other: _____

(1) What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ GDM ☐ Don't Know

(2) Year/Age of Diabetes Diagnosis: _____ / _____ List relatives with diabetes: _____

(3) Do you take diabetes medications? ☐ Yes *(check all that apply below)* ☐ No

☐ Diabetes Pills ☐ Insulin Injections ☐ Byetta Injections ☐ Symlin Injections ☐ Combination of pills/injections

About how often do you miss taking your medicine as prescribed? _____

(4) Do you have other health problems? ☐ Yes *Please list other conditions:* _____ ☐ No

(5) Do you take other medications? ☐ Yes ☐ No *Please list other medications:* _____

(6) What is the last grade of school you have completed? _____

(7) Are you currently employed? ☐ Yes ☐ No *If yes, 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 Providers ☐ Support Group

☐ No One ☐ Other: _____

(11) Do you have a meal plan for diabetes? ☐ Yes ☐ No *If yes, please describe:* _____

About how often do you use this meal plan? ☐ Never ☐ Seldom ☐ Sometimes ☐ Usually ☐ Always

Do you read and use food labels as a dietary guide? ☐ Yes ☐ No

Do you have any diet restrictions? ☐ Salt ☐ Fat ☐ Fluid ☐ None ☐ Other: _____

Give a sample of your meals for a typical day:

Time: _____ Breakfast: _____

Time: _____ Lunch: _____

Time: _____ Dinner: _____

Time: _____ Snack: _____

(12) Do you do your own food shopping? ☐ Yes ☐ No Cook your own meals? ☐ Yes ☐ No

How often do you eat out? _____

(13) Do you drink alcohol? ☐ Yes ☐ No *Type:* _____ *How many?* _____ ☐ *per day* ☐ *per week* ☐ *occassionally*

(14) Do you use tobacco? ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chewing ☐ None ☐ Quit (*How long ago:* _____)

(15) Do you exercise regularly? ☐ Yes ☐ No How often? _____

My exercise routine is: ☐ easy ☐ moderately intense ☐ very intense

(16) Do you check your blood sugars? ☐ Yes ☐ No Blood Sugar Range: _____ to _____

How often do you check? ☐ Once a day ☐ 2 or more a day ☐ 1 or more a week ☐ Occasionally

When: ☐ Before breakfast ☐ 2 hours after meals ☐ Before bedtime *Target Blood Sugar Range:* _____

S&W SCOTT&WHITE Healthcare | Brenham

Scott & White Diabetes Education Center
2111 S. Day Street | Brenham, Texas 77833 | 979-830-5017

(17) In the last month, how often have you had a low blood sugar reaction? ☐ Never ☐ Once ☐ 1 or more ☐ ____ times/week

What are your symptoms? _____

(18) Can you tell when your blood sugar is too high? ☐ Yes ☐ No

What do you do when your sugar is high? _____

(19) Check any of the following tests/procedures you have had in the last 12 months:

☐ Dilated Eye Exam ☐ Urine Test for Protein ☐ Dental Exam ☐ Foot Exam _____ *(Self)* _____ *(Healthcare Professional)*

☐ Blood Pressure ☐ Weight ☐ Cholesterol ☐ HgA1c ☐ Flu Shot ☐ Pneumonia Shot

(20) In the last 12 months, have you: ☐ Used emergency room services ☐ Been admitted to a hospital

Was the ER visit or hospital admission diabetes-related? ☐ Yes ☐ No

(21) 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? ☐ Yes ☐ No *How long ago:* _____

(23) In your own words, what is diabetes? _____

(24) How do you learn best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing

(25) Do you have any difficulty with? ☐ Hearing ☐ Seeing ☐ Reading ☐ Speaking

Explain any checked: _____

(26) Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ☐ Yes ☐ No

If yes, please describe: _____

(27) Do you use computers: ☐ To email ☐ Look for health or other information

(28) Please state whether you agree, are neutral, or disagree with the following statements:

I feel good about my general health: ☐ Agree ☐ Neutral ☐ Disagree

My diabetes interferes with other aspects of my life: ☐ Agree ☐ Neutral ☐ Disagree

My level of stress is high: ☐ Agree ☐ Neutral ☐ Disagree

I have some control over whether I get diabetes complications or not: ☐ Agree ☐ Neutral ☐ Disagree

I struggle with making changes in my life to care for my diabetes: ☐ Agree ☐ Neutral ☐ Disagree

(29) How do you handle stress? _____

(30) What concerns you most about your diabetes? _____

(31) What is hardest for you in caring for your diabetes? _____

(32) What are your thoughts and feelings about this issue (i.e. frustrated, angry, guilty)? _____

(33) What are you most interested in learning from these diabetes education sessions? _____

_____

(34) Pregnancy and Fertility - Are you: ☐ Pre-menopausal ☐ Menopausal ☐ Post-Menopausal ☐ N/A

Are you pregnant? ☐ Yes (*When are you expecting?* ____/____/____) ☐ No (*Are you planning on becoming pregnant?* _____)

Have you been pregnant before? ☐ Yes ☐ No Do you have any children? ☐ Yes (*list ages*: _____) ☐ No

Are you aware of diabetes' impact on pregnancy? ☐ Yes ☐ No Using birth control? ☐ Yes (*specify*: _____) ☐ No

OFFICE USE ONLY: Please do not write below this line.

CLINICIAN ASSESSMENT SUMMARY: _____

_____

_____

_____

Education Needs/Plan: ☐ Diabetes Disease Process ☐ Nutritional Management ☐ Physical Activity ☐ Using Medications

☐ Preventing Acute Complications ☐ Preventing Chronic Complications ☐ Behavior Change Strategies ☐ Monitoring

☐ Risk Reduction Strategies ☐ Psychosocial Adjustment

Clinician Signature: _____ **Date:** _____