DIABETES EDUCATION PARTICIPANT SELF ASSESSMENT

Name: _____Date: _____/_____/_____

I prefer to be called :_____

Date of Birth:____/____/_____ Age: _____

Current Medications (Please complete your current medication list):

	Medication Name	Dose	Frequency	Date Last Taken:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5 .	_____	_____	_____	_____
6.	_____	_____	_____	_____

(Please use the back page of this questionnaire for additional medications)

Allergies (Please list any allergies to medication and what happens if you take that medication)

_____ _____

_____ _____

Medical History (Please circle all that apply)

Coronary Heart disease Congestive Heart Failure High blood pressure Stroke Thyroid Disease
High Cholesterol Other: _____

Family History of Diabetes (Please list relatives with diabetes)

_____

_____

Do you drink alcohol? (Please circle yes or no) Yes No

If yes: type? _____ how often? _____ how much? _____

Do you use tobacco? (Please circle those that apply)

None Cigarette Pipe Cigar Chewing Quit – when? _____

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General Information (Please circle all that apply)

Who came with you today? No One Spouse Partner Mother Father Caregiver

Other: _____

Doctor who referred you: _____

What type of Diabetes do you have? (Please circle one) Type 1 Type 2 Pre-diabetes I don't know

Date of Diabetes Diagnosis: (mo./day/year) _____/_____/_____

Have you had education on the care of your diabetes? (Please circle Yes or No) Yes No

If yes, How long ago? _____

Type of diabetes education: (Please circle all that apply)

Read material on diabetes Taught by someone about diabetes /diet

Attended diabetes education class before

Lifestyle / Health (Please circle / answer):

Do you exercise? Yes No Type: _____

How often? _____

Have you had a flu shot? Yes No If yes, when? _____

Have you had a pneumonia shot? Yes No If yes, when? _____

How many people live in your household? _____

Do you believe your health is: Excellent Good Fair Poor

Do you believe the stress in your life is: Low Medium High

What causes your stress? Finances Family Health Work Other _____

How do you handle stress? _____

Do you have support for your diabetes from: Family Friends Co-worker No One

Other:_____

What are your feelings about diabetes? frustrated angry guilty other:_____

Please circle 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

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

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Are you currently employed? Yes No Retired

What type of work do you do? _____

Nutrition History (Please circle / answer):

Height: _____ Weight: _____ Preferred weight: _____

Do you limit: Sugar Salt Fat

Do you do your own food shopping? Yes No Do you cook your own meals? Yes No

How often do you eat out? _____

***What I Usually Eat* - Food, Drinks, Amounts and Where I Eat**

Breakfast Time		Where?
Snack Time		Where?
Lunch Time		Where?
Snack Time		Where?
Dinner Time		Where?
Snack Time		Where?

Blood Glucose (sugar) Testing

Do you check your blood glucose? (Please circle Yes or No) Yes No

If Yes, what brand name of glucose meter do you use? _____

If Yes, has your doctor given you a target glucose range? (Please circle Yes or No) Yes No

What is your usual range? _____

Foot Care

Are you able to care for your feet, including clipping toenails? (Please circle Yes or No) Yes No

If no, who cares for your feet? (Please circle all that apply):

Podiatrist Nurse Family member Salon Other:_____

Health History (Please circle / answer)

Please circle any of the following tests/procedures you have had in the last 12 months and fill in any results that you know:

Dilated eye exam Urine test for protein Foot exam: self healthcare professional

Dental exam Blood pressure /Result?_____/date____/____/_____

Cholesterol /Result?_____/date____/____/_____

Hemoglobin A1C /Result?_____/date____/____/_____

In the last 12 months, have you used emergency room services or been admitted to a hospital? If yes, please circle which one. Was the ER visit or hospital admission diabetes related? Yes No N/A

In the last month, how often have you had a low blood glucose reaction: (Please circle one)

Never Once One or more times

What are your symptoms?_____

How do you treat your low blood glucose?_____

Can you tell when your blood glucose is too high? Yes No

What do you do when when your sugar is high? _____

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Learning Needs (Please circle / answer)

What concerns you most about your diabetes?_____

What is hardest for you in caring for your diabetes?

_____

Readiness to learn: Accepting Denying No interest Refuse

How would you rate you understanding of diabetes? Good Fair Poor

Please list two things that you want to learn from your diabetes education visit today:

1) _____

2) _____

How do you learn best? (Please circle *all* that apply): Listening Reading Observing Demonstration

What is the last year of school completed? _____

Do you have any difficulty with: (circle *all* that apply) Hearing Seeing Reading Speaking

Financial Mobility: wheelchair walker cane skooter

Explain any checked: _____

Do you have any cultural or religious practices or beliefs that influence how you take care of your diabetes? Yes No

If yes, please describe: _____

For Women:

Are you planning on becoming pregnant? Yes No

Are you aware of the impact of diabetes on pregnancy? Yes No

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