

DI ABETES SELF-CARE QUESTI ONNAI RE



PERSONAL HI STORY

Name _____

Address _____ Phone:(H) _____
_____ (W) _____
_____ (email address) _____

Birthdate ____ \ ____ \ ____ Marital Status ____ (S,M,D,W) Male ____ Female ____

Ethnic origin/race: African American/Black American Indian White
 Asian/Pacific Islander Hispanic Other _____

Primary Ancestry: Arab/Chaldean Finnish Hispanic Other _____

Number of persons living in your household: _____

Occupation: _____ Place of Work _____

Highest grade of education completed: _____

Do you read English? Yes ____ No ____ If no, what language do you read? _____

How do you learn best? (Check all that apply) Reading ____ Video/TV ____ Group classes ____
One on one instruction ____ Other _____

DI ABETES HI STORY

How long have you had diabetes? _____ (month/years)

What type of diabetes do you have? Type 1 ____ Type 2 ____ Gestational ____ Unknown ____ Pre-Diabetes ____

Other family members with diabetes: Father Mother Other

Have you had diabetes education before? Yes ____ No ____ If yes, date _____

Have you ever been in the hospital because of diabetes? Yes ____ No ____
Explain _____

Do you carry diabetes identification? Yes ____ No ____

How do you describe your general health? Excellent ____ Good ____ Fair ____ Poor ____

How often do you see your doctor for your diabetes? _____

When was your last glycohemoglobin/A1c (3 month average) done? _____

Results _____

PRESCRIPTION MEDICATIONS:

<u>Name</u>	<u>Dose/Amount</u>	<u>Time Taken</u>	<u>Reason for taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

NON PRESCRIPTION MEDICATIONS: (i.e. vitamins, supplements)

<u>Name</u>	<u>Dose amount</u>	<u>Time Taken</u>	<u>Reason for taking</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have any allergies to medicines? _____

IF YOU TAKE INSULIN, PLEASE ANSWER THE FOLLOWING QUESTIONS

How long have you been taking insulin? _____

Do you give your own shots? Yes ___ No ___ If no, who does? _____

What areas of your body do you give your shots? (Please check all that you use)

Abdomen ___ Thigh ___ Arms ___ Buttocks ___ Other _____

How do you dispose of your insulin syringes? _____

LOW BLOOD SUGAR:

How many times in the **past month** have you had a low blood sugar symptoms? _____

How do you treat these symptoms? _____

GENERAL HEALTH:

When was your last dilated eye exam? _____ Name of eye doctor _____

Do you have any eye problems? _____

When was your last dental exam? _____

Have you seen a podiatrist about your feet? Yes ___ No ___

If yes, what doctor? _____ When? _____

Do you have any of the following problems? Thick toenails ___ calluses ___ poor circulation in feet
___ dry skin ___ foot ulcers/sores ___ numbness, tingling in feet ___ other _____

Please describe _____

Do you check your feet everyday? Yes ___ No ___

Do you smoke tobacco? Yes ___ No ___ If yes, how long? _____

Have you thought about quitting? Yes ___ No ___

Do you drink alcohol? Yes ___ No ___ If yes, how much and how often? _____

Do you have high blood pressure? Yes ___ No ___ Do you know what it is? _____

Do you know your cholesterol level? Yes ___ No ___ If yes, what is it? _____

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

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

DO YOU HAVE OTHER HEALTH PROBLEMS?

MEAL PLANNING

Height _____ Current weight _____

Do you have any food allergies? _____

Have you ever met with a dietitian about your diabetes meal plan? Yes ___ No ___

Did the dietitian give you a meal plan? Yes ___ No ___

Do you skip meals? (Circle all that apply) Breakfast Lunch Supper Snacks

Who does the food shopping? _____ Cooking? _____

With whom do you usually eat? _____

How many times a week do you eat at a fast food/restaurant for the following meals? (e.g. 1-2 times)

Breakfast _____ Lunch _____ Supper _____

Have you had any recent weight changes (within the last year)? Yes ___ No ___

If yes, please explain: _____

DIABETES MANAGEMENT:

BLOOD SUGAR TESTING

Do you test your blood sugar? Yes ___ No ___

What type of meter (machine) do you use? _____ How old is it? _____

What time of day do you test? _____

Do you use the control solutions to test your meter for accuracy? Yes ___ No ___

Do you report your blood sugar results to your doctor? Yes ___ No ___

SOCIAL/EMOTIONAL

What are your feelings/beliefs about your diabetes?

- | | | |
|------------------|--------------------|----------------------------|
| 1. Surprised ___ | 4. Unconcerned ___ | 7. Confident _____ |
| 2. Depressed ___ | 5. Relieved ___ | 8. Motivated to change ___ |
| 3. Fearful ___ | 6. Accepting ___ | 9. Other _____ |

Do your family/friends help you to manage your diabetes? Yes ___ No ___

Do you feel you can afford the items you need to manage your diabetes? Yes ___ No ___

If no, what is it that you need? _____

Do you have religious practices/cultural beliefs that affect how you care for your diabetes? Yes ___ No ___

Do you have problems that are causing stress in your life? (e.g. family problems, medical problems, financial problems) _____

How do you cope with stress? (e.g. overeating, meditating, drinking alcohol)

Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes ___ No ___

Within the last year, has anyone forced you to have sexual activities? Yes ___ No ___

ACTIVITY LEVEL:

Do you exercise (times a week?) 0 1-2 3-4 5-7

What kind of exercise do you do? (i.e. walk, swim, bicycle) _____

How long do you exercise at each session? (i.e. 10 minutes) _____

Is there a limit to exercise for health reasons? _____

UNDERSTANDING OF DIABETES

What topics do you need to know more about to help you care for your diabetes:

- Basics of diabetes, relationship of diet, medicine, exercise
- Meal planning
- Medications
- High blood sugar/low blood sugar
- Blood sugar testing and equipment
- Chronic complications of diabetes
- Exercise
- Staying healthy/reduction of risk factors
- Stress reduction
- Preparing for pregnancy/gestational diabetes
- Other

What are your main concerns and/or goals for your diabetes education sessions with us?

PROGRAM USE ONLY:

REVIEWED BY: _____