

**SPARROW HEALTH SYSTEM
DIABETES SELF-CARE QUESTIONNAIRE**



PERSONAL HI STORY

Name _____ Due Date: _____
Address _____ Phone:(H) _____
_____ (W) _____
_____ (email address) _____

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

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 ____ Lecture ____ Video/TV ____

Group classes ____ One on one instruction ____ Other _____

Do you smoke tobacco? Yes ____ No ____ If yes, how long have you smoked? _____

Have you thought about quitting? Yes ____ No ____

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

DI ABETES HI STORY/PREGNANCY HI STORY

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

Other family members with diabetes: Father Mother Other _____

Have you been diagnosed with Gestational diabetes in the past? Yes ____ No ____

Birth weight(s) of previous pregnancies _____

Complications during previous pregnancies (including stillbirths) _____

MEDI CATI ONS:

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

Over the counter/non prescription: (i.e. vitamins, supplements)

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

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? _____

MEAL PLANNING

Height _____ Current Weight _____ Prepregnancy Weight _____

Do you have any food allergies _____

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

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

With whom do you usually eat? _____

How many times a week do you eat at a fast food and/or other restaurant for: (e.g. 1 – 2 times)

Breakfast ___ Lunch ___ Supper ___

DIABETES MANAGEMENT:

BLOOD SUGAR TESTING

Do you test your blood sugar? Yes ___ No ___

What type of meter (machine) do you use? _____

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 ___

PSYCHOSOCIAL

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 or cultural beliefs that affect how you care for your diabetes? Yes ___ No ___

Comments: _____

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

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 ___

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

What are your concerns regarding this pregnancy? _____

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? (i.e. bed rest) _____

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

_____ Exercise

_____ Staying healthy/reduction of risk factors

_____ 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: _____