SPARROW HEALTH SYSTEM

DIABETES SELF-CARE QUESTIONNAIRE

PERSONAL HISTORY

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_____________________________

DIABETES HISTORY

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:

Name	Dose/Amount	Time Taken	Reason for taking

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

Name	Dose amount	Time Taken	Reason for taking

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?____________

Do you have any eye problems?____

When was your last dental exam?____

Have you seen a podiatrist about your feet? Yes ____ No ____ When _____

Do you have any of the following problems? (*Circle those that apply)*

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 ___ If yes, what is it?________________________

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/s of day do you test?____

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

SOCIAL/EMOTIONAL

What are your feelings/beliefs about your diabetes? ***(Circle those that apply)***

Surprised	Unconcerned	Confident
Depressed	Relieved	Motivated to change
Fearful	Accepting	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?) *Circle appropriate response*: 0 times 1-2 times 3-4 times 5-7 times

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:

___ Healthy eating

___ Being active

___ Monitoring

___ Taking medications

___ Problem solving

___ Reducing risks

___ Healthy coping

___ Preparing for pregnancy/gestational

___ Pump Education

___ Other

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

____

____

____

PROGRAM USE ONLY:

REVIEWED BY:____