Diabetes Education & Management Center

Self Assessment of Diabetes Management

MR#: ______________

DSME ______
Appt:
CDE ______
Date ______
Time ______

Name: ______________________ Daytime Phone: ( ) ____________ Date: __________

Date of Birth: ____/____/____ Age: _____ Gender: ❑ F ❑ M Height: __________ Weight: ________

Ethnic Background: ❑ White/Caucasian ❑ Black/African American ❑ Hispanic ❑ Native American ❑ Middle-eastern

What is your language preference: ❑ English ❑ Other: ______________________

Day time Phone: ( ) ______________________

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 and injections
   About how often do you miss taking your medication as prescribed? ______________________

4. Do you have other health problems? ❑ Yes ❑ No Please list other medical conditions: ______________________

5. Do you take other medications? ❑ Yes ❑ No Please List : ______________________

6. What is the last grade of school you have completed? ______________________

7. Are you currently employed? ❑ Yes ❑ No 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

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:

Breakfast	Lunch	Dinner
Snack	Snack	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 ❑ occasionally

14. Do you use tobacco: ❑ cigarette ❑ pipe ❑ cigar ❑ chewing ❑ none ❑ quit, how long ago ______________________

15. Do you check your blood sugars? ❑ Yes ❑ No Blood sugar range: __________ to __________
    How often: ❑ Once a day ❑ 2 or more/day ❑ 1 or more/week ❑ Occasionally
    When: ❑ Before breakfast ❑ 2 hours after meal ❑ Before bedtime What is your target blood sugar range?
    ____

16. In the last month, how often have you had a low blood sugar reaction: ❑ Never ❑ Once ❑ One or more times/ week
    What are your symptoms? ______________________ How do you treat your low blood sugar? ______________________
    Name of meter: ______________________

17. Can you tell when your blood sugar is too high? ❑ Yes ❑ No What do you do when your sugar is high? ______________

18. Check any of the following tests/procedures you have had in the last 12 months:
    ❑ dilated eye exam ❑ urine test for protein ❑ foot exam--self ❑ foot exam –health care professional ❑ dental exam
    ❑ blood pressure ❑ weight ❑ cholesterol ❑ HgA1c ❑ flu shot ❑ pneumonia shot

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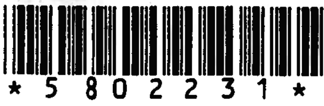

Participant Self Assessment of Diabetes Management

19. In the last 12 months, have you: ❑ used emergency room services ❑ been admitted to a hospital
Was ER visit or hospital admission diabetes related? ❑ Yes ❑ No

20. 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

21. Have you had previous instruction on how to take care of your diabetes? ❑ Yes ❑ No How long ago: ______________

22. In your own words, what is diabetes? ______________________________

23. How do you learn best? ❑ listening ❑ reading ❑ observing ❑ doing

24. Do you have any difficulty with: ❑ hearing ❑ seeing ❑ reading ❑ speaking
Explain any checked: ______________________________

25. Do you use computers: ❑ to email ❑ look for health and other information

26. 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

27. How you handle stress? ______________________________

28. What concerns you most about your diabetes? ______________________________

____

29. What is hardest for you in caring for you diabetes? ______________________________

30. What are your thoughts or feelings about this issue (e.g., frustrated, angry, guilty)? ______________________________

____

31. What are you most interested in learning from these diabetes education sessions? ______________________________

____

32. Pregnancy and Fertility:
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 -- Ages: ______________ ❑ No
Have you had gestational diabetes? ❑ Yes ❑ No
Are you aware of the impact of diabetes on pregnancy? ❑ Yes ❑ No
Are you using birth control? ❑ Yes--please specify ______________ ❑ No

DO NOT WRITE BELOW THIS LINE

CLINICIAN ASSESSMENT SUMMARY: ______________________________

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Education Needs/Education Plan: ❑ Diabetes disease process ❑ Nutritional Management ❑ Physical Activity ❑ Using Medications ❑ Monitoring ❑ Preventing Acute Complications ❑ Preventing Chronic Complications ❑ Behavior Change Strategies ❑ Risk Reduction Strategies ❑ Psychosocial adjustment

Date: ______________ Clinician Signature: ______________________________