IF YOU HAVE A METER TO CHECK YOUR BLOOD SUGAR, PLEASE BRING IT TO YOUR FIRST EDUCATION APPOINTMENT

Questionnaire for Diabetes Self-Management

Have you had previous instruction or ever had anyone teach you about caring for your diabetes?

☐N ☐Y How long ago? _____

Date of Birth: ___/___/____ Age: _____ Gender: ☐F ☐M Height: _____ Weight:_____

Ethnic Background: ☐White/ Caucasian ☐Black/African American ☐Hispanic

☐Native American- Alaska Native ☐Asian/ Pacific Islander ☐Other: _____

What type of diabetes do you have? ☐type 1 ☐type 2 ☐don't know

When were you diagnosed? _____ Family history of diabetes? ☐N ☐Y

Do you take diabetes medications? ☐N ☐Y If yes, please list: 1. _____

2. _____ 3. _____ 4. _____

During a typical month, how many times do you miss taking your medications on average?

☐None ☐once or twice ☐three to five ☐more than 5 times

Do you have other health problems? ☐N ☐Y Please list: _____

_____

Do you take other medications? ☐N ☐Y Please list: _____

_____

What is the last grade of school you completed? _____

Are you comfortable filling out medical forms by yourself? ? ☐N ☐Y

Are you currently employed? ☐N ☐Y Work hours: _____ Occupation? _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

How many people live in your household? _____How are they related to you? _____

From whom do you get support to manage and cope with your diabetes? ☐Family ☐Coworkers

☐Healthcare providers ☐Support group or diabetes "buddy" ☐Social media ☐No one

Do you follow a specific meal plan? ☐N ☐Y Please describe: _____

About how often do you use this meal plan? ☐Never ☐Seldom ☐Sometimes ☐Usually ☐Always

Do you read and use food labels? ☐N ☐Y

Diet restrictions: ☐Salt ☐Fat ☐Fluid ☐Gluten ☐None ☐Other _____

Do you do your own shopping? ☐N ☐ Y Cook your own meals? ☐N ☐Y

How often do eat out, carry out or use drive thru?

☐Rarely ☐Once a week ☐2-3 times a week ☐Once a day ☐Every meal

Do you drink alcohol? ☐N ☐Y Type: _____

How much: ☐Occasionally ☐1-3 drinks / week ☐1-2 drinks/ day ☐More than 2 drinks/ day

Give a sample of your meals for a typical day:

Do you eat breakfast? ☐N ☐Y	Time:	Give an example :
Do you eat a midmorning snack? ☐N ☐Y	Time:	Give an example:
Do you eat lunch? ☐N ☐Y	Time:	Give an example:
Do you eat an afternoon snack? ☐N ☐Y	Time:	Give an example:
Do you eat supper? ☐N ☐Y	Time:	Give an example:
Do you eat a snack at night? ☐N ☐Y	Time:	Give an example:

Do you use tobacco? ☐Cigarette ☐Pipe ☐Cigar ☐Chewing ☐None ☐Quit- how long ago? _____

Do you exercise regularly? ☐N ☐Y Type: _____ How often: _____

Exercise routine is: ☐Easy ☐Moderately intense ☐Very intense

How many hours a day do you spend sitting? ☐2 or less ☐ 3-5 ☐6-9 ☐More than 9 hours

Do you check your blood sugars? ☐N ☐Y Usual blood sugar range: _____ to _____

How often do you check? ☐Once a day ☐2 or more/ day ☐1 or more/ week ☐Occasionally

When: ☐Before meals ☐2 hours after meals ☐Before bedtime

Do you know what your target is? ☐N ☐Y Target: _____ to _____

How would you best describe your results over the last month? _____

Result of last Hemoglobin A1c: _____

How often do you have a blood sugar below 70 mg/dl? ☐Never ☐Once ☐One or more times / week
What are your symptoms? _____

How do you treat your low blood sugar? _____

How often do you have blood sugar above 160 mg/dl? ☐Never ☐Once ☐One or more times / week
What do you do when your blood sugar is high? _____

Do you ever check your urine for ketones? ☐N ☐Y When? _____
Check any of the following tests/ procedures you have had in the last 12 months:

☐Dilated eye exam ☐Urine tests for protein ☐Dental exam ☐Foot exam ☐Blood pressure

☐Weight ☐Cholesterol ☐Hemoglobin A_1c ☐Flu shot ☐Pneumonia shot

In the last 12 months, have you: ☐Gone to the emergency room (ER) ☐Been admitted to the hospital

If so, was it diabetes related? ☐N ☐Y

Do you have any of the following: ☐Eye problems ☐Kidney problems ☐Dental problems

☐Numbness/ tingling/ loss of feeling in your feet ☐High blood pressure ☐High Cholesterol

☐Sexual problems ☐Depression

Do you check your feet every day? ☐N ☐Y
In your own words, what is diabetes: _____

_____

How do you learn best? ☐Listening ☐Reading ☐Observing ☐Doing

Do you have any difficulty with: ☐Hearing ☐Seeing ☐Reading ☐Speaking
Explain any checked: _____
Do you have any special cultural or religious observances, practices or beliefs that influence how you

care for your diabetes? ☐N ☐Y Please describe: _____

Do you use computers to: ☐Email ☐Look for health and other information

Please tell us:	Not at all	Somewhat	Very
*I feel good about my general health:	☐	☐	☐
*My diabetes interferes with other aspects of my life:	☐	☐	☐
*My overall level of stress is high:	☐	☐	☐
*I often feel as if I am failing in managing my diabetes:	☐	☐	☐
*I often feel overwhelmed by the demands of living with diabetes:	☐	☐	☐
*I feel I will get long term complications no matter what I do:	☐	☐	☐
*I am ready to make lifestyle changes to help my diabetes:	☐	☐	☐

How do you handle stress in your life? _____

_____

What concerns you most about your diabetes? _____

_____

What is hardest for you in caring for your diabetes? _____

_____

What are you most interested in learning from these diabetes education sessions? _____

_____

Are you: ☐Pre-menopausal ☐Menopausal ☐Post- menopausal ☐N/A

Are you pregnant? ☐N/A ☐N ☐Y When are you expecting? _____

Are you planning on becoming pregnant? ☐N/A ☐N ☐Y

Have you been pregnant before? ☐N/A ☐N ☐Y

Do you have any children? ☐N/A ☐N ☐Y Ages: _____

Are you aware of the impact of diabetes on pregnancy: ☐N/A ☐N ☐Y

Are you using birth control? ☐N/A ? ☐N ☐Y Please specify: _____

Signature: _____ Date: _____