Diabetes Education Assessment

Your Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.

First Name_____ Middle Name _____
Last Name _____ Suffix _____

Street Address _____
City_____ State _____ Postal Code _____

Work Phone _____ Home Phone _____
Cell Phone _____ Email _____
Insurance Type_____

Demographics

Date of Birth _____ ☐ Male ☐ Female

Healthcare Provider for your diabetes care_____

Race
☐ American Indian or Alaskan Native
☐ Asian/Chinese/Japanese/Korean
☐ Black/African American
☐ Hispanic/Chicano/Latino/Mexican
☐ White/Caucasian
☐ Native Hawaiian or Other Pacific Islander
☐ Middle Eastern
☐ Other
☐ Do Not Know

Preferred Language: ☐ English ☐ Spanish ☐ Other

Education (highest level completed)
☐ 8th Grade or less ☐ Some High School ☐ High School Graduate /GED
☐ Some College ☐ College Degree (BA/BS) ☐ Graduate Degree

How did you find out about the program?
☐ Brochure ☐ Community Calendar ☐ Facebook ☐ Friend
☐ Website ☐ Health Fair ☐ Library ☐ Newspaper
☐ Healthcare Provider_____ ☐ Other_____

Health Questions

1. **What type of diabetes do you have?** ☐ Type 1 ☐ Type 2 ☐ Gestational
   ☐ Pre-diabetes ☐ Do not know

2. **What year were you diagnosed?** _____

3. **Do any of these below get in the way of your learning something new?**

   ☐ Seeing ☐ Reading ☐ Hearing ☐ Not good with numbers ☐ Do not read well
   ☐ Physical difficulty ☐ Writing ☐ English as a second language
   ☐ Other_____ ☐None of the above

4. **Which way do you best like to learn something new?**
   ☐ Reading ☐ Videos ☐ Group Discussion ☐ Listening to topic being explained
   ☐ Hands on demonstration

5. **Check Below what you would like to learn more about**:
   ☐ Diabetes, What Is It
   ☐ Long-term Complications (eyes, kidneys, heart problems, feet, dental, skincare)
   ☐ High and Low Blood Sugars and Sick Day Rules
   ☐ My Diabetes Medications
   ☐ Importance of Monitoring My Diabetes
   ☐ Importance of Physical Activity and My Diabetes
   ☐ Healthy Coping with Diabetes
   ☐ Healthy Eating with Diabetes
   ☐ All the Above
   ☐What to Know Before Becoming Pregnant, Gestational Diabetes Management

6. **What is the main thing you want to learn about to better help you take care of your own diabetes? Be as specific as possible please.**

   _____

   _____

7. **In the past 12 months, have you been to the hospital for <u>your diabetes</u>?**
   ☐ Yes ☐ No

8. **In the past 12 months, have you had an emergency room visit for <u>your diabetes</u>?**
☐ Yes ☐ No

9. **When was your last dilated eye exam?** Month_____Day _____Year_____
If you do not know, what is the approximate time? _____

10. **Consider the degree to which the two items below may have distressed or bothered you <u>within the past month</u>:**

A. Do you have feelings of being overwhelmed by the demands of living with diabetes?

☐ Not a problem ☐ A slight problem ☐ A moderate problem
☐ Somewhat serious problem ☐ A serious problem ☐ A very serious problem

B. Do you have feelings that you are often failing with your diabetes routine?

☐ Not a problem ☐ A slight problem ☐ A moderate problem
☐ Somewhat serious problem ☐ A serious problem ☐ A very serious problem

11. **How many days in an average week do you miss your medicine?**
☐ 0 ☐ Less than 1x ☐ 1 ☐ 2-3 ☐ 4-6 ☐ 7 more

12. **Reasons you feel you miss your medicine:** ☐ Forgot ☐ Too Often ☐ Side Effects
☐ Too Complicated ☐ Don't need it ☐ Doesn't work ☐ Too depressed
☐ Cost too much ☐Other_____

13. **Please list the medicines you take for diabetes (name, how much and when):**

Diabetes Pills_____

Insulin_____

Other Medicine (Byetta, Victoza, Bydureon, Symlin)_____

Please list other medications, how much and when you take them on last page or attach a list what you take.

14. **Do you check your blood sugar at home**? ☐ Yes ☐ No
How often to you do blood sugar checks? _____ times per day
What is your blood sugar goal? _____

15. Have you had a high blood sugar in the last month (blood sugar reading higher than 180)? ☐ Yes ☐ No ☐ Don't know

16. How often do you have blood sugar readings over 180? ☐ 1-3 times a week ☐ 4-6 times a week ☐ 7 or more times a week ☐ Rarely ☐ Don't know

17. How often do you have low blood sugar symptoms? ☐ 1-3 times a week ☐ 4-6 times a week ☐ 7 or more times a week ☐ Rarely ☐ Don't know

A. **Is there a time of day this usually happens?** ☐ Yes ☐ No
   If yes, when? _____
B. **How did you feel with the low blood sugar?** _____
C. **How did you treat your low blood sugar?** _____

18. Do you have a sick day plan? ☐ Yes ☐ No

19. Do you wear diabetes identification? ☐ Yes ☐ No

20. Do any of the following things prevent you from taking care of yourself?

☐ Housing ☐ Transportation ☐ Support Network
☐ Utilities ☐ Caregiver ☐ None of the above
☐ Food ☐ Cannot do usual self-care activities
☐ Other_____

21. State your general feelings about your overall health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

22. Have you ever been diagnosed with depression? ☐ Yes ☐ No

23. Do you feel overwhelmed by the demands of your diabetes?

☐ No ☐ Some ☐ A Lot

24. Over the past two weeks, how often have you been bothered by any of the following problems? Please choose the appropriate response for each item:

Little interest or pleasure in doing things

☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

Feeling down, depressed or hopeless

☐ Not at all ☐ Several days ☐ More than ½ the days ☐Nearly every day

25.Do you have any of the following health problems?

☐ Heart attack or stroke

☐ Amputation (toe, foot, leg)

☐ Kidney problems (Nephropathy)

☐ Eye problems (Retinopathy)

☐ Foot problems (sores, callus, swelling, numbness)

☐ Sexual problems

☐ Stomach/digestive problems

☐ Teeth/Dental

☐ High blood pressure

☐ Pain/burning/numbness or loss of feeling in feet (Neuropathy)

☐ High Cholesterol /Triglycerides

☐ Overweight or Underweight

☐ Arthritis

☐ Thyroid

☐ Osteoporosis

26. Do you have any other health problems? (please list): _____

_____

27. Do you have a history of Tobacco or Nicotine use?

☐ Yes ☐ No ☐ Quit How long ago?_____years

28. Did you ever go to counseling for tobacco/nicotine use? ☐ Yes ☐ No

29. What type of tobacco do you use?

☐ Cigarettes ☐ E-Cigarettes ☐ Cigars ☐ Pipes ☐ Chew ☐ Snuff

30. How much tobacco do you use (packs, cans, cigars, E-Cigarettes etc. per day)? _____

31. Do you drink alcohol? ☐ Regularly (few times per week) or ☐ Socially (few times per month/year) ☐ No ☐ Quit?

32. Who do you live with?

☐ Live alone ☐ With children only ☐ With spouse or partner
☐ With parents only ☐ With spouse/partner and children
☐ With other family members or friends ☐ Other_____

33. Who helps you with your diabetes?

☐ Self ☐ Spouse ☐ Child ☐ Non-Relative ☐ Other_____

34. Do you ever have trouble problems paying for your diabetes medicine, supplies or food? ☐ Yes ☐ No ☐ Don't know

35. Have you ever had diabetes education? ☐ Yes ☐ No ☐ Don't know

If Yes, date you received your diabetes education? Month_____ Day ____Year_____

36. Have you ever had education with a Registered Dietitian or MNT related to your diabetes? ☐ Yes ☐ No

37. Have you made changes in how you eat since finding out you have diabetes?

☐ Yes ☐ No ☐ Don't know

If yes, what type of changes have you made? ☐ Eat Less ☐ Eat More Vegetables
☐ Eat Less Sugar ☐ Eat Less Fat ☐ Drink Less Pop, Juice
Other _____

38. Which meals do you tend to skip? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ None

39. Who does the cooking in your house? ☐ Self ☐ Spouse ☐ Other_____

40. How often do you eat out during the week?

☐ None ☐ One time ☐ Two times ☐ Three time ☐ Four or more times

41. Do you have any special dietary needs? ☐ Yes ☐ No

Please list: _____

42. Does your culture or religion require fasting or dietary restrictions?

☐ Yes ☐ No _____

43. How many days a week do you have increased physical activity/exercise?

☐ 0 day ☐ 1day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days

44. On a day you exercise, how many total minutes do you spend exercising?

☐ 15 minutes or less ☐ 30 minutes ☐ 45 minutes ☐ 60 minutes
☐ more than 60 minutes

45. What type of exercise do you do?

☐ Walking ☐ Bike riding ☐ Sports (basketball, softball, etc.)
☐ Running ☐ Golfing ☐ Fast Activity (Aerobics)
☐ Swimming ☐ Tennis ☐ Weight lifting/ Strength training
☐ Dancing ☐ None ☐ Other _____

46. How often do you look at the <u>top</u> and <u>bottoms</u> of your feet closely for problems?

Please choose **only one** of the following:

☐ Daily ☐ Once a month ☐ Never
☐ Few times a week ☐ Less than once a month
☐ Once a week ☐ Few times a month

45. *Women Only*

Do you use *birth control?* ☐ Yes ☐ No Type_____

Are currently pregnant ☐ Yes ☐ No

Are you planning to get pregnant? ☐ Yes ☐ No

46. What is your most recent blood pressure result?

Top Number_____ Bottom Number _____ ☐ Do not know

47. Which of the following tests/exams have you had in the last 12 months?

☐ Flu shot ☐ Kidney test ☐ Dental exam ☐ Complete physical
☐ Foot exam by doctor ☐ Cholesterol test ☐ Blood pressure ☐ Weight
☐ Dilated eye exam: month_____

48. When was your last A1C Test (3 month blood sugar test)?

Approximate Date_____ ☐ Don't Know ☐ Never had one

49. Result of last A1C? _____ ☐ Don't Know

50. When was your last pneumonia shot? Month_____ Day _____Year_____

51. Have you ever had Hepatitis B shots (3 shots)? ☐ Yes ☐ No

Thank you for completing your self –report.

The information you supplied will provide your diabetes care team with a better picture of your diabetes.

Participant Signature/Date:_____

Verbal Consent/Information Obtained from Participant: ☐ Yes ☐ No Date_____

Diabetes Educator Signature/Date:_____

Please list additional medications on back.

Medications: (list ALL medications; prescription/over the counter & herbals)

NAME	DOSE **(# mg)**	FREQUENCY **(how often)**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____