Western Washington Medical Group

Nutrition & Diabetes Education

SELF ASSESSMENT OF DIABETES MANAGEMENT

Name:		
Date of Birth: / /	Age:	Gender: □ F □ M
1. What type of Diabetes do you have? □ Type 1 □ Type 2 □ Gestational □ Pre-Diabetes □ Don't know		
2. Year/Age of diabetes diagnosis:	Relatives with diabetes:	
3. Do you take diabetes medications? □ Y (check all that apply below) □ No □ Diabetes pills □ Insulin injections □ Other injections About how often do you miss taking your medication as prescribed? _____ Do you experience difficulty affording your medications or supplies? □ Y □ N Have you taken other medications for diabetes in the past? □ Y □ N If yes, which medications: _____ Did you experience any intolerances or side effects from previous medications? □ Y □ N		
4. Do you have other health problems? □ Y □ N Please list other medical conditions:		
5. Do you take other medications? □ Y □ N Please list other medications:		
6. Check any of the following tests/procedures you have had in the last 12 months: □ dilated eye exam □ urine test for protein □ foot exam □ dental exam □ blood pressure □ weight □ cholesterol □ A1c □ flu shot □ pneumonia shot		
7. In the last 12 months, have you: □ used the emergency room □ been admitted to the hospital If yes, was the visit related to your diabetes? □ Y □ N Have you been admitted to the hospital or seen in the emergency room for Diabetes Ketoacidosis (DKA)? □ Y □ N If yes, when: _____ How often have you had DKA? _____		
8. Do you have any of the following: □ eye problems □ kidney problems □ numbness or tingling in hands/feet □ dental problems □ dentures □ high blood pressure □ high cholesterol □ sexual problems		
9. Pregnancy and Fertility: Are you: □ pre-menopausal □ menopausal □ post-menopausal □ N/A Are you pregnant? □ Y □ N If so, when are you expecting? _____ If not, are you planning on becoming pregnant? □ Y □ N Have you been pregnant before? □ Y □ N If previously pregnant, were you diagnosed with gestational diabetes? □ Y □ N If so, how was it managed? □ diet and exercise □ insulin □ oral diabetes medications Are you aware of the impact that diabetes may have on pregnancy? □ Y □ N Are you using birth control? □ Y □ N		
10. What is the last grade of school you completed?		
11. Are you currently employed? □ Y □ N If yes, what is your occupation?		
12. From whom do you get support for your diabetes? □ Family □ Friends □ Co-workers □ Support group □ Healthcare provider □ No one		
13. What are your feelings about your diabetes? □ frustrated □ angry □ guilty □ other:		
14. How do you manage stress?		

15. 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

16. Have you had previous diabetes education? □ Y □ N If yes, when:

17. In your own words, describe diabetes:

18. How do you learn best? □ listening □ reading □ observing □ doing

19. Do you have any difficulty with: □ hearing □ reading □ seeing □ manual dexterity/fine motor skills

20. Do you have a meal plan for your diabetes? □ Y □ N
If so, how often do you use this meal plan? □ Never □ Seldom □ Sometimes □ Usually □ Always
Do you read and use food labels? □ Y □ N How often do you eat out?
Do you do your own food shopping? □ Y □ N Do you cook your own meals? □ Y □ N

21. Do you drink alcohol? □ Y □ N Type: How many? □ Daily □ Weekly □ Monthly

22. Do you use tobacco? □ Y □ N Type: Quit: how long ago?

23. Are you physically active? □ Y □ N Type: Days/week active?
List any barriers to being physically active:

24. Do you have any cultural or religious practices or beliefs that influence how you manage your diabetes?
□ Y □ N Please describe:

25. Do you check your blood sugar: □ Y □ N What is your usual range: _____
When do you check: □ before breakfast □ 2 hours after meals □ before meals □ before bedtime
What is your target range? _____

26. In the last month, how often have you had low blood sugar? □ Never □ Once □ More than once
At what number do you feel low? _____ What are your symptoms? _____
How do you treat a low blood sugar?

27. Can you tell when your blood sugar is too high? □ Y □ N
What do you do when your blood sugar is high?

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

CLINIC USE:

Education Plan: □ Diabetes disease process □ Nutrition □ Physical activity □ Using medications □ Monitoring □ Preventing acute complications □ Preventing chronic complications □ Behavior change □ Risk reduction □ Psychosocial adjustment

Clinician: _____ Date: _____