Diabetes Management Self Assessment

Name:			Today's Date:	
Address:			Date of birth:	
City:	State:	Zip:	Check preferred contact # below:	
Work Location:			☐ Home Phone	
Email: (optional)			☐ Work Phone	
Marital status: S M D W			☐ Cell phone:	

Gender: ☐ Female ☐ Male Race:

Current Weight : _____ pounds Height: _____

1. How long have you had diabetes? ☐ New diagnosis ☐ _____months ☐ _____years

What type of diabetes do you have? ☐ Type 1 diabetes ☐ Type 2 diabetes ☐ Pre-Diabetes ☐ Not sure

Other: _____

2. Health Status:

How often do you go to the doctor for diabetes? _____ time(s) a year ☐ Newly diagnosed/don't know

$HgbA1_C$ Date	Result _____%		☐ Do not know	☐ Not done
How often do you go to the eye MD?	_____ time(s) every year		☐ Do not go	☐ Infrequently
Vision problems?	☐ Yes		☐ No	☐ Do not know
Dilated eye exam? Date	☐ Normal	☐ Retinopathy	☐ Not done	☐ Do not know
Heart problems/ Heart Surgery?	☐ Yes	Yr____	☐ No	☐ Do not know
Heart attack?	☐ Yes	Yr____	☐ No	☐ Do not know
EKG? Date	☐ Normal	☐ Abnormal	☐ Not done	☐ Do not know
Lipid test Date	_____ Cholesterol	_____ HDL _____ LDL	_____ Triglycerides	☐ Not done ☐ Do not know
High blood pressure?	☐ Yes		☐ No	☐ Do not know
Stroke?	☐ Yes	Yr_____	☐ No	☐ Do not know
Kidney problems?	☐ Yes		☐ No	☐ Do not know
Frequent infections?	☐ Yes Type:_____		☐ No	☐ Do not know
Foot exam by MD Date	☐ Foot problems present		☐ No problems	☐ Not done
Pain/numbness/burning in feet or legs?	☐ Yes		☐ No	
Do you practice daily foot care?	☐ Yes		☐ No	
Amputation?	☐ Yes_____		☐ No	Yr _____

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2. Health Status: (cont.)

How often do you go to the dentist? _____ time(s) every yr	☐ Do not go	☐ Infrequently	
Dental problems?	☐ Yes _____	☐ No	
Sexual difficulties ?	☐ Yes _____	☐ No	
How often do you exercise? _____ time(s) per wk / Type_____		☐ Do not exercise	
Do you follow a meal plan for your diabetes?	☐ Yes	☐ No	
Do you manage your diabetes differently when you are sick?	☐ Yes	☐ No	
Have you had a flu shot within the last 12 months?	☐ Yes	☐ No	
Have you ever had a shot to prevent pneumonia?	☐ Yes Yr____	☐ No	
Do you smoke/use tobacco? (if yes, amount: _____)	☐ Yes	☐ No	
Do you drink alcohol? (amount/frequency:_____)	☐ Yes	☐ No	
Within the last year, how many times have you:			
Been in the emergency room? _____ time(s) For diabetes:	☐ Yes	☐ No	
Been a patient in the hospital?_____ time(s) For diabetes:	☐ Yes	☐ No	

On a scale of 1 – 5, how would you rate your overall health?

☐ 1 – Poor ☐ 2 – Fair ☐ 3 – Good ☐ 4 – Very Good ☐ 5 – Excellent

3. Allergies to Food or Medications:_____

4. DiabetessMedications: Check the type of diabetes med(s) you are taking and list dose and when taken:

Biguanide

Metformin
☐ Glucophage
☐ Fortamet
☐ Riomet
☐ Glucophage XR/Glumetza (metformin extended release)

Dose: _____
When taken:
_____

Combinations: see next pg

DPP-4 Inhibitor
☐ Januvia
☐ Onglyza
☐ Tradjenta

Dose:
_____
When taken:
_____

Sulfonylurea
☐ DiaBeta (glyburide)
☐ Micronase (glyburide)
☐ Glynase (glyburide)
☐ Glucotrol (glipizide)
☐ Glucotrol XL (glipizide)
☐ Amaryl (glimepiride)

Dose: _____
When taken:
_____

Glitazone (TZD)
☐ Avandia (rosiglitazone)
☐ Actos (pioglitazone)

Dose: _____
When taken:
_____

SGLT2 Inhibitors

☐ Invokana (canagliflozin)
☐ Farxiga (dapagliflozin)
☐ Jardiance (empaglizflozin)
Dose: _____
When taken:
_____

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☐ Glucovance (glyburide & metformin) ☐ Avandamet (rosiglitazone & metformin) **Dose:** _____ **When taken:** _____	☐ Duetact™ (pioglitizone and glimeperide) ☐ Janumet™ (sitagliptin and metformin) **Dose:** _____ **When taken:** _____	☐ Metaglip (glipizide & metformin) ☐ Actoplus Met (Pioglitazone & metformin) ☐ Avandamet (rosiglitazone & glimeperide) ☐ Jentadueto (linagliptin/metformin) **Dose:** _____ **When taken:** _____

Check the type of all injectable diabetes medication(s) you are currently taking:

Insulin			**Other**
☐ Humalog (lispro) ☐ NovoLog (aspart) ☐ Apidra (glulisine) **Humulin/Novolin** ☐ **R** (Regular) **Dose(s) and when**: _____ _____	**Humulin/Novolin** ☐ **N** (NPH) ☐ 70/30 ☐ 50/50 **Dose(s) and when**: _____ _____ _____	**Humalog/Novolog Mix** ☐ 70/30 ☐ 50/50 ☐ 75/25 **Dose(s) &** **When:**_____ _____	☐ Byetta (exenatide) ☐ Victoza (liraglitide) ☐ Tanzeum (albiglutide)) ☐ Bydureon (exeratide extended) **Dose(s) and when**: _____ _____
		☐ Lantus (glargine) ☐ Levemir (detemir) **Dose(s) and When**:_____	

Do you use an insulin pump? ☐ Yes/ Type_____ Basal Rates_____ ☐ No

5. Other Medications: Please list all the non diabetes medications you take along with the dose, time and reason for taking the medication (Use back of form **OR attach a list for additional medications**):

Name of medication	Dose	Time Taken: (Daily, Mealtime, PM, Bedtime)	Reason

Any Side Effects from any of your meds ? ☐ Yes ☐ No If yes, which ones and what?_____

_____Have you discussed this with your MD? ☐ Yes ☐ No

Do you take **over-the counter** meds or **herbals/supplements/vitamins**? ☐ Yes * ☐ No

*Attach list or use back of form

6. Low blood glucose/sugar (**hypoglycemia**):

Has your blood glucose ever dropped too low? ☐ Yes ☐ No ☐ Do not know

How would you feel when you have low blood glucose? ☐ Do not know

_____

What do you do when your blood glucose is low? ☐ Do not know

What do you have with you to treat low blood glucose?_____ ☐ Nothing

Do you wear diabetes identification? ☐ Yes ☐ No

Diabetes Identification/brochure provided ☐ Yes ☐ No

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7. Blood glucose **monitoring**: ☐ Have meter Type_____ ☐ Do not have meter

How often do you check your blood glucose? _____times every ☐ day ☐ week ☐ month ☐ Do not check

What is an acceptable blood glucose range? _____ ☐ Do not know

Do you have problems getting testing supplies? ☐ Yes ☐ No

8. For **Women**: Are you using some type of birth control? ☐ Yes What?_____ ☐ No

___

☐ Post-menopausal ☐ Surgery (tubal or hysterectomy

Are you now or planning to become pregnant? ☐ Yes ☐ No

9. Stress and Support Systems: On a scale of 1 – 5, how would you rate your stress level?

☐ 1- Very low stress ☐ 2- Low stress ☐ 3- Moderate stress ☐ 4-High stress ☐ 5- Very high stress

Do you have family and friends that you can turn to when you need support? ☐ Yes ☐ No

10. Schedule and **Learning Needs:** How much school completed _____

Are you employed? ☐ Yes ☐ No

How many hours do you usually work? _____ What type of work do you do?_____

What hours do you usually work: ☐ Days ☐ Evenings ☐ Nights ☐ Rotate shifts

List any language, religious, cultural, financial factors that we need to consider in working with you on your diabetes management plan: _____ ☐ None

How do you learn best? ☐ Reading ☐ Demonstration ☐ Discussion ☐ Other _____

How ready are you to make changes in managing your diabetes?

☐ 1- Not ready ☐ 2- May be ready ☐ 3- Somewhat ready ☐ 4- Ready ☐ 5- Very ready

What are you most interested in learning about your diabetes? (check boxes below)

☐ General info ☐ Physical activity ☐ Acute complications (low blood sugar/illness, etc.)

☐ Medications ☐ Blood glucose monitoring ☐ Chronic complications (cardiac, kidney, eyes, feet, etc)

☐ Meal planning ☐ Preconception care ☐ Other (list): _____

What do you want to accomplish by attending this program? _____

_____

Have you ever used services at this hospital before? ☐ Yes ☐ No

Instructor Signature /Credentials Date