marinhealth℠

BRADEN DIABETES CENTER

SELF-ASSESSMENT QUESTIONNAIRE

Thank you for completing the questionnaire – please answer as best you can!

Name ____ Age _______ ☐ Male ☐ Female

Occupation: __________________________________ ☐ Not working ☐ Retired from: ____________

Education: ☐ Some high school ☐ High school graduate ☐ Some college ☐ College graduate

Ethnic Background: ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander
☐ White- Hispanic ☐ White- non-Hispanic ☐ Other________________________ ☐ Unknown

Living Situation: I live with ☐ Spouse/Partner ☐ Single/Live Alone ☐ Divorced/Separated ☐ Widow/Widower
☐ Retirement Home ☐ Other: _____________________________________

Does anyone help you with your healthcare needs? ☐ No ☐ Yes: _______________________________

Are there any issues that would interfere with your ability to learn? ☐ No ☐ Yes

If yes, (*please select*): ☐ Visual ☐ Hearing ☐ Reading ☐ Language ☐ Cognitive ☐ Other: ___________

Are there any language, religious or cultural factors to consider in teaching you? ☐ No ☐ Yes
If yes, please explain: ____

Learning Preference (*check all that apply*): ☐ Demonstration ☐ Reading/Handouts ☐ Class ☐ Computer

Please provide email address to receive our monthly newsletter (optional): __________________________

MEDICAL HISTORY

Height: _____ft. _____in. Weight: ________lbs. Do you have a preferred weight? ___________ lbs.

Has your weight changed recently? ☐ No ☐ Yes If yes, how many lbs. gained/lost? __________ lbs.

Have you ever participated in a weight loss program? ____

Please select all current and former medical conditions or problems you have experienced:

☐ High blood pressure ☐ High cholesterol ☐ Heart problems ☐ Circulation problems

☐ Stroke/TIA ☐ Thyroid ☐ Kidney / Liver ☐ Gastrointestinal problems

☐ Foot/nerve problems ☐ Depression ☐ Other psychiatric ☐ Eye problems

☐ Gum problems ☐ Other: ____

☐ History of infection or non-healing wound: ____

Please select any of the following you've had in the last year:

☐ Medical check-up ☐ Dental check-up ☐ Dilated eye exam ☐ Foot exam ☐ Psychotherapy

☐ Kidney Function (urine protein test) ☐ Annual flu vaccination ☐ Pneumonia vaccination

List any major operations / recent hospitalizations: ____

PATIENT LABEL

YOUR DIABETES HISTORY

What is your most recent A1C result? A1C________% Approx. date: ___________ ☐ Not sure/don't know

How long have you had diabetes? ____

Do you have any relatives with diabetes? ☐ No ☐ Yes: ______________________________

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

How would you rate your understanding of diabetes? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any previous diabetes education? ☐ No ☐ Yes If yes, when? ______________________

Do you have a history of hospitalization related to diabetes? ______________________________

How do you feel about having diabetes? ____

What is your main reason for coming today? ____

MONITORING YOUR BLOOD SUGAR

Do you test your blood sugar? ☐ No ☐ Yes If yes, which meter do you use: ______________________

How often do you test? ☐ Occasionally ☐ Every few days ☐ Daily ☐ Multiple times per day

What time(s) of day do you test? ____

Do you ever have **low** blood sugar events? ☐ No ☐ Not sure ☐ Yes, how often? ______________

Do you have symptoms when **low**? ☐ No ☐ Yes (describe) ______________________________

Is your blood sugar ever **over** 200mg/dl? ☐ No ☐ Not sure ☐ Yes, how often? ______________

Do you have symptoms when **high**? ☐ No ☐ Not sure ☐ Yes (describe) ______________

MEDICATIONS

In the last two months, have you skipped/forgotten to take your medication? ☐ Yes ☐ No

If yes, list the reasons (check all that apply): ☐ Forgot ☐ Financial ☐ Ran out ☐ Side effects

Do you carry a list of your medications? ☐ Yes ☐ No

Do you wear an insulin pump and/or continuous glucose monitor? ☐ Yes ☐ No

If yes, list the type(s):____

Please list **all** prescribed medications you take:

1) ____________________________ ______________ dosage ________________ frequency

2) ____________________________ ______________ dosage ________________ frequency

3) ____________________________ ______________ dosage ________________ frequency

4) ____________________________ ______________ dosage ________________ frequency

5) ____________________________ ______________ dosage ________________ frequency

PATIENT LABEL

NUTRITION

Do you follow a meal plan? ☐ No ☐ Yes If yes, what type? ______________________

Who does the cooking at your home? ______________ Who does the shopping? ______________

Do you have any problems purchasing food? ☐ No ☐ Yes: ______________________

Do you have problems chewing or swallowing your food? ☐ No ☐ Yes: ______________________

Do you wear dentures? ☐ No ☐ Yes If yes, do they fit well? ______________________

Do you have food allergies? ☐ No ☐ Yes If yes, please specify: ______________________

Can you share what foods raise blood sugar? ☐ No ☐ Yes If yes, please list: ______________________

How many meals a week do you eat out? ☐ 0 - 1 ☐ 2 - 4 ☐ 4 - 7 ☐ 8 or more

List restaurants, fast food, etc. where you visit: ______________________

Do you skip meals? ☐ No ☐ Yes

If yes, which meals do you tend to skip? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Other: ______________

How many meals do you typically eat each day? ______________ How many snacks do you eat? ______________

Please provide an example of a ***typical*** day of food/drink intake:

Breakfast: ______________________

Snack: ______________________

Lunch: ______________________

Snack: ______________________

Dinner: ______________________

Snack: ______________________

How do you feel about your food choices? ☐ Good ☐ Needs improving ☐ Not sure

ACTIVITY

Do you do physical activity on a REGULAR basis? ☐ No ☐ Yes How many times a week? ______________

How long are you active? ☐ 1 – 30 min ☐ 31 – 60min ☐ 60+ min

What type of activity do you do? ______________________

Do your break a sweat? ☐ Yes ☐ No Does your heart rate increase? ☐ Yes ☐ No

Are there any medical reasons that limit/stop you from daily activity? ☐ Yes ☐ No

If yes, please explain: ______________________

PATIENT LABEL

LIFESTYLE

Do you use tobacco? ☐ No ☐ Yes If yes, what type? __________ Amount _____ per day/week (circle one)

Have you tried to quit? ☐ No ☐ Yes Do you have any interest in resources to stop smoking? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes If yes, what do you drink? ______________________________

Amount ______________________ per day/week/month (circle one)

How many hours of sleep each night do you get? ____________ Sleep quality: ☐ Good ☐ Fair ☐ Poor

Rate the level of stress in your life: ☐ Low ☐ Medium ☐ High ☐ Very high

How do you cope with your stress? ____

How would you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

YOUR LEARNING OBJECTIVES

Please mark all topics you are interested in learning about.

____ **What is diabetes (causes, diagnosis, symptoms)?**

____ **Nutrition**
- ____ Healthy eating for diabetes
- ____ Carbohydrate counting
- ____ Individualized meal plan

____ **Physical Activity**
- ____ Activity for blood sugar control & weight loss

____ **Medications**
- ____ Medications usage & options
- ____ Types of insulin & administration
- ____ Insulin pumps
- ____ Continuous glucose monitor

____ **Monitoring Blood Glucose**
- ____ Glucose meter usage & blood glucose targets
- ____ How to understand your blood glucose readings

____ **Prevention of Complications**
- ____ High / low blood sugar range and what to do
- ____ Understanding lab results (A1C, Cholesterol)
- ____ Steps to prevent complications & illness
- ____ Foot care and diabetes
- ____ Traveling and diabetes

____ **Coping, Stress**

____ **Setting and Reaching Goals**

Anything else? ____

PATIENT LABEL