Cooley Dickinson Medical Group
Diabetes Center
Self-Assessment of Diabetes Management

CDMG 2504 Rev 7/17

Name:

D.O.B.

Med. Rec.#

Name: Date:

Date of Birth: Age: Gender: ☐ F ☐ M

Ethnic background: ☐White/Caucasian ☐ Black/A-A ☐Hispanic ☐Native American ☐Middle Eastern ☐Asian/PI ☐Other:

SOCIAL HISTORY

1. Do you use tobacco: ☐ cigarette ☐ pipe ☐ cigar ☐ chewing ☐ none ☐quit How long ago ____

2. Do you exercise regularly? ☐ Y ☐ N Type: _____ How often: _____
What other physical activities do you do regularly as part of your daily living? ☐ Housework ☐ Gardening ☐Farming ☐ Climbing stairs Other _____ ☐None

3. Do you drink alcohol? ☐ Y ☐ N Type:
How many per day__ per week __ Occasionally__

4. What is the last grade of school you have completed?

5. Are you currently employed? ☐ Y ☐ N What is your occupation?

6. Marital status: ☐ single ☐ married ☐ divorced ☐ widowed

7. Do you live: ☐ alone ☐ spouse ☐ children # ☐housemate ☐other:

8. Do you use any recreational drugs?

9. What is your language preference? ☐English ☐Other:
Do you have any difficulty ☐reading ☐ writing ☐ understanding English

DIABETES CARE

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

2. Year/Age of diabetes diagnosis: List relatives with diabetes:

3. Do you wear medical ID? ☐ Y ☐ N

4. From whom do you get support for your diabetes? ☐ Family ☐ Co-workers ☐ Healthcare providers ☐ Support group ☐ Friends ☐ No one

5. Do you have a meal plan for diabetes? ☐ Y ☐ N If yes, please describe:
_____
How often do you use this meal plan? ☐Never ☐Seldom ☐Sometimes ☐Usually ☐Always
Do you read and use food labels as a dietary guide? ☐Y ☐N
Do you have any dietary restrictions? ☐ Salt ☐ Fat ☐ Fluid ☐None Other: _____

6. Do you do your own food shopping? ☐ Y ☐ N Do you cook your own meals? ☐Y ☐ N
How often do you eat out?

7. Do you check your blood sugars? ☐Y ☐ N Blood sugar range: _____ to _____
How often: ☐ Once a day ☐ 2 or more a day ☐1 or more/week ☐ Occasionally
When: ☐ Fasting ☐ 2 hours after meals ☐ Before meals ☐ Before bedtime
What is your target blood sugar range? Meter type: _____

8. In the last month, how often have you had a low blood sugar reaction? Never ☐ Once ☐
☐ One or more times per week _____times per day When do they occur? _____
What are your symptoms? How do you treat your low blood sugar?

9. Can you tell when your blood sugar is too high? ☐ Y ☐N At what number do you feel it _____
What do you do when your sugar is high?

10. Check any of the following tests/procedures/visits you have had in the last 12 months:
☐Dilated eye exam ☐urine test for protein ☐foot exam: self ☐healthcare professional ☐dental exam
☐Blood pressure ☐weight ☐ cholesterol ☐ HgbA1C ☐flu shot ☐pneumonia shot

11. In the last 12 months, have you: ☐ used emergency room services ☐ been admitted to a hospital
Was ER or hospital visit diabetes related? ☐ Y ☐ N

12. Do you have any of the following: □ eye problems □ kidney problems □ high cholesterol
□ numbness/tingling/loss of feeling in your feet □dental problems □ high blood pressure
□sexual problems □Depression □ sleep problems

13. Do you have other health problems? □ Y □ N Please list other health conditions:

14. Have you had previous instruction on how to take care of your diabetes? □Y □ N How long ago?

15. Do you take other medications? □ Y □ N Please list other medications:

16. In your own words, what is diabetes?

17. How do you learn best: □ Listening □ Reading □Observing □ Doing

18. Do you have any difficulty with: □Hearing □ Seeing □ Reading □Speaking
Explain any checked:

19. Do you use computers: □ to e-mail □ to look for health and other information

20. Please answer the following statements:
I feel □ Good □ Ok □Poor about my general health
My diabetes interferes with other aspects of my life: □ Agree □Neutral □Disagree
My level of stress is: □high □ low □moderate
I have control over whether I get diabetes complications or not:
□ some control □ no control □ complete control
I □ struggle □ do not struggle □sometimes struggle with making changes in my life to care for my diabetes.

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

22. Are you currently seeing a counselor? □Yes □No □ In the past?
What do you do when you are stressed?

23. What concerns you most about your diabetes?

24. What is hardest for you in caring for your diabetes?

25. What are your thoughts or feelings about having diabetes?

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

_____

What are you most interested in changing about how you currently care for your diabetes?

_____

How motivated/confident are you that you can/will make this change? (use scale below to answer)

Least amount of motivation/confidence = 1 2 3 4 5 6 7 8 9 10 = greatest amount of motivation/confidence

27. **Pregnancy and Fertility:**
Are you: □ Pre-menopausal □ Menopausal □Post-menopausal □N/A
Are you pregnant? □Y □N When are you expecting? _____
Are you planning on becoming pregnant? □ Y □N
Have you been pregnant before? □Y □ N How many times? _____
Do you have any children? □Y □N ages: _____
Are you aware if the impact of diabetes on pregnancy? □Y □N
Are you using birth control? □Y □N Please specify: _____

FOOD INTAKE SUMMARY

In the space below, please record what you typically eat in a 24-hour period. Include all snacks and beverages:

Breakfast	**Lunch**	**Dinner**
Time:	Time:	Time:
Morning Snack	**Afternoon Snack**	**Evening Snack**
Time:	Time:	Time:

Beverages: (How much and how often)

Juice:
Soda:
Water:
Caffeine (coffee, tea, energy drinks):

How many alcoholic drinks do you have per week? _____
What kind? ☐ Beer ☐ Wine ☐ Mixed drinks

Notes:

Diabetes Treatment:

☐ Diet ☐ Exercise ☐ Oral Agents ☐ Insulin ☐ Syringes ☐ Pens ☐ Insulin Pump

Diabetes Medication/ Insulin	Dose	Time	Frequency / Sites	Equipment Used, Brand/Type (Syringes, Pen, Needles, Pump)
☐ Insulin injections				
☐ Byetta/Victoza injections				
☐ Symlin injections				

How often do you miss taking medication as prescribed? _____
Do you reuse needles? ☐ Yes ☐ No If yes, how long? _____
How do you dispose of needles? _____
Angle of injection? ☐ 45˚ ☐ 90˚
Do you adjust your medications? o yes o no Which ones? _____
How do you store your insulin? _____
Have you been instructed on Glucagon? ☐ Yes ☐ No If yes, where is your Glucagon located?
_____
Who knows how to use it? _____
Do you have any Lipohypertrophy? ☐ Yes ☐ No Where? _____

Completed by _____ Print name _____
Relationship to patient _____ Date _____

CLINICIAN ASSESSMENT SUMMARY:

Clinician Signature: _____ Print:_____ Date:_____ Time:_____