UNIVERSITY of MARYLAND
ST. JOSEPH MEDICAL CENTER

Participant Self-Assessment of Diabetes Management

Name: _____ Date: _____

Date of Birth: _____ Age: ____ Gender: __ F __ M

Ethnic Background: □White/Caucasian □Black/African American □Hispanic □Native American-Alaska
□Asian/Pacific Islander □Middle-Eastern □ Other: _____
What is your language preference: □English □Spanish □ Other: _____
Marital Status: □ Single □ Married □ Divorced □Widowed
Number of people who live in your household: ___ How are they related to you: _____
Last grade of school you completed: _____
Employed: □Yes □No □Retired □Disabled □Other
Vision Problems □Yes □No Do you wear glasses/contact lens: □Yes □No
Hearing Problems □Yes □No Do you wear hearing aid: □Yes □No
How do you best learn: □Reading □Demonstration □Visual □Verbal □Combination
Preferred method of learning: □Individual □Group

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

2. Year/Age of diabetes diagnoses: _____

3. Any family history of diabetes? □Yes □No Whom: _____

4. Do you take diabetes medications: □Yes □No
How often do you miss taking your medications on average during a typical month?
_____

5. List all the medications you take <u>including dose and times OR attach a current medication list</u>:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. Do you have any allergies to medication, food or other: □Yes □No

List: _____
_____

7. Do you have any other health problems? □Yes □No
Please list other health conditions: _____
_____

8. Have you had any surgery: □Yes □No
List: _____
_____

9. Dentist: date of last visit: _____

10. Dilated eye exam: date of last visit: _____ □Has one scheduled □Never had one

11. Foot exam: have you had a foot exam by a physician: □Yes □No
Date of last exam: _____ □Unsure

12. Do you check your feet every day: □Yes □No □Not sure why I should check

<u>Monitoring</u>

13. Do you monitor your blood sugar: □Yes □No
Name of Meter: _____
Do you have supplies at home: □Yes □No
How many times a day do you test your blood sugar: _____
When: □before breakfast □before lunch □before dinner □bedtime □2 hours after meals
□other times: _____
Range of BS before breakfast: _____
Range of BS before lunch: _____
Range of BS before dinner: _____
Range of BS 2hours after a meal: _____
What is your target blood sugar: _____

14. Do you keep a record of your BS: □Yes □No
□Logbook □Phone app □Meter Memory □Other

15. Do you test your urine or blood for ketones: □Yes □No

16. What was your last A1c: _____ Date: _____ □Unsure □ Not sure what an A1c test is

17. In the last month, how often have you had a low blood sugar reaction?
□Never □Once □One or more times/week

What are your symptoms? _____
How do you treat low blood sugar? _____

18. Can you tell when your blood sugar is too high? □Yes □No
What do you do when your sugar is high? _____

Meals

19. Do you use any particular guidelines for a specific meal plan? □Yes □No
If yes, please describe: _____
_____
About how often do you use this meal plan?
□Never □Seldom □Sometimes □Usually □Always
Do you read and use food labels as a dietary guide? □Yes □No
Do you have any dietary restrictions: □Salt □Fat □Fluid □None □Other _____
How many meals do you eat a day: _____ Do you skip meals: □Yes □No
Do you eat snacks: □Yes □No How many a day: _____
List all things you drink: _____

Meals

Give a sample of your meals for a typical day:
Time: _____ Breakfast: _____
Time: _____ Lunch: _____
Time: _____ Dinner: _____
Time: _____ Snack: _____

20. Do you do your own food shopping? □Yes □No Cook your own meals? □Yes □No
How often do you eat out? _____

Exercise

21. Do you exercise regularly? □Yes □No Type: _____ How Often: _____
My exercise routine is: □easy □moderately intense □very intense

Tests/Procedures

22. Check any of the following tests/procedures 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 □A1c □Flu shot □Pneumonia shot

23. In the last 12 months, have you: □used emergency room services □been admitted to a hospital
Was ER visit or hospital admission diabetes related? □Yes □No

Other problems

24. Do you have any of the following: □eye problems □kidney problems □high blood pressure
□numbness\tingling loss of feeling in your feet □dental problems □high cholesterol

□sexual problems □depression

Previous diabetes Education

25. Have you had previous instruction on how to take care of your diabetes? □Yes □No
When: _____
26. In your own words, what is diabetes? _____
_____

27. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes: □No □Yes: please describe: _____

Support and Coping

29. From whom do you get support to manage and cope with your diabetes?
□ Family □Co-workers □Health-care providers □Support group or diabetes buddy
□Social media □No one

30. 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

31. How do you handle stress? _____

32. What concerns you most about your diabetes? _____

33. What is the hardest for you in caring for your diabetes? _____
_____
How do you feel about this? (e.g., frustrated, angry, guilty)? _____
_____

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

Pregnancy and Fertility: (Females)

35. Are you: □Pre-menopausal □Menopausal □Post-Menopausal □N/A
36. Are you pregnant? □Yes Due date? _____

□No Are you planning on becoming pregnant? _____

37. Have you been pregnant before? □No □Yes Do you have children? □Yes: Ages: ___ □No
38. Are you aware of the impact of diabetes on pregnancy? □Yes □No
39. Are you using birth control? □Yes □No

Please do not write below this line

Education Needs/Education Plan: □Diabetes Disease Process □Nutritional Management
□Physical Activity □Using Medications □Monitoring □Preventing Acute Complications
□ Preventing Chronic Complications □Behavior Change Strategies □Psychosocial Adjustment

Date: _____ Clinician Signature: _____