Diabetes Self-Care Assessment  Date: ________________

Personal Information:

Name: ________________________________

Are you:  ☐ Married  ☐ Single  ☐ Widowed  ☐ Other_____________________

Do you live:  ☐ Alone  ☐ with Spouse  ☐ with Others

Do you have any condition that affects your ability to take part in a class?  ☐ Yes  ☐ No

If yes, please describe: ______________________________________________________________________

Are you hard of hearing?  ☐ Yes  ☐ No  Do you have problems with your vision?  ☐ Yes  ☐ No

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Diabetes History

When were you told you have diabetes? ________________________________

Do other family members have diabetes?  ☐ Parents  ☐ Children  ☐ Siblings  ☐ Other _________________

Have you had diabetes education in the past?  ☐ Yes  ☐ No  When _________________

Do you have low blood sugars?  ☐ Yes  ☐ No  How many times per day _______ time per week________

Do you carry something with you for low blood sugar?  ☐ Yes  ☐ No  What _________________

Do you check your blood sugar?  ☐ Yes  ☐ No  Name of your meter _________________________________

How often _____________  What is your average blood sugar before eating ________    After eating ________

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Diabetes Care

When was your last complete physical? ________________________________

When was your last dilated eye exam? ________________________________

When did your last dental exam? ________________________________

How often does your doctor check your feet? ________________________________

How often do you check your feet?  ☐ Daily  ☐ Weekly  ☐ Rarely  ☐ Never

Have you had a flu vaccination within the last year?  ☐ Yes  ☐ No

Have you had a pneumonia vaccination?  ☐ Yes  ☐ No

Do you carry emergency diabetes identification?  ☐ Yes  ☐ No
**Medications**

Please bring a list of all your medications to your first visit, including “over the counter” medications like aspirin, pain relievers, vitamins and supplements.

Do you take pills for your diabetes?  □ Yes  □ No  How often do you skip a dose? ____________________
Do you have trouble getting medications?  □ Yes  □ No  Cost ___ Other ______________________________

Do you take insulin for your diabetes?  □ Yes  □ No  How often do you skip a dose? ____________________
Where do you give your shots?  □ Abdomen  □ Arms  □ Legs  □ Other______________________________
Do you adjust the amount of insulin to take?  □ Yes  □ No
Where do you keep your insulin you are using now? ________________  Extra supply? ________________
Insulin delivery device: Pens _____ Vial / syringe _____ Insulin pump _____

Type of Insulin:  Humalog  Novolog  Apidra  R (Regular)  U500  
Lantus  Levemir  Tresiba  Toujeo  N (NPH)  
Humulin 70/30  Humalog 75/25  Humalog 50/50  Novolog 70/30

How much insulin do you take? (List type and amount of each insulin)

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**Health History**

Have you been to ER, urgent care or admitted to the hospital for your diabetes in the last year?  □ Yes  □ No
Do you use tobacco?  □ Yes  □ No  If yes, would you like information about quitting?  □ Yes  □ No
Do you drink alcohol?  □ Yes  □ No  If yes, how much per day? ______ per week? ______

Are you being treated for any of these conditions?

□ High blood pressure  □ Heart disease  □ Eye disease
□ Sleep apnea  □ Allergies  □ High cholesterol / triglycerides
□ Depression  □ Other ______________________________
### Health History continued

Do you have any of the following?

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- Stomach problems, (bloating, fulling full)
- Numbness, pain or tingling in the feet
- Any sores that will not heal
- Feeling tired or weak
- Sexual problems
- Would you like information?
  - Yes
  - No

### Mobility

Do you have any concerns about your mobility?

- ☐ Yes
- ☐ No

Do you use a walker, cane, or wheel chair?

- ☐ Yes
- ☐ No

Have you fallen in the last six months?

- ☐ Yes
- ☐ No

### Activity

Are you active in your daily life?

- ☐ Yes
- ☐ No

Do you have an exercise plan?

- ☐ Yes
- ☐ No

Type of exercise ______________________________________________________________________

How many days per week? _________________ For how long? ______________________________________________________________________

Do you have low blood sugars with activity?

- ☐ Yes
- ☐ No

### Food and Nutrition

Do you follow a special plan or eating guidelines?

- ☐ Yes
- ☐ No

If yes, please explain: ______________________________________________________________________

How many meals do you eat per day? ______________________________________________________________________

Do you snack between meals?

- ☐ Yes
- ☐ No

If yes, when? ______________________________________________________________________

Do you want to lose weight?

- ☐ Yes
- ☐ No

Do you have food allergies?

- ☐ Yes
- ☐ No

If yes, what? ______________________________________________________________________
Diabetes and Emotions

Diabetes affects the whole person. People can feel sad, angry or overwhelmed at times because of it. It is important to identify those types of feelings. Otherwise, it may be difficult to take care of your diabetes. The following questions ask about such feelings. Please answer YES or NO.

Have you been feeling sad...depressed? ............................................ YES NO
Are you getting less pleasure from your job, sports, hobbies? .................. YES NO
Do you often feel TIRED? ................................................................. YES NO
Do you have trouble sleeping or do you sleep too much? ..................... YES NO
Have you been gaining or losing weight without trying? ....................... YES NO
Do you often feel agitated or like you can barely move? ....................... YES NO
Do you have trouble making decisions or concentrating on your work? ...... YES NO
Do you often feel down on yourself, that everything is your fault? ........... YES NO
Do you ever feel that life isn't worth living? ...................................... YES NO
Do you have thoughts of hurting yourself? ...................................... YES NO
Do you feel you need to see a psychiatrist for treatment? ..................... YES NO

Circle any words that describe how you currently feel about your diabetes and how it affects you:
Overwhelmed Out of control Harassed Burdened Alone Angry

What is your greatest fear about having diabetes? ____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

This class should help you with the things that concern you most about your diabetes. Please list anything you want to learn or change about your diabetes.

1. __________________________________________________________________________________________
2. __________________________________________________________________________________________
3. __________________________________________________________________________________________
Medication Reconciliation (per patient)

**Allergies and Adverse Reactions:**

**Current Medications:** Include all prescribed medications, over-the-counter and herbal medications.

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Patient’s Signature  ______________________________

Date

Educator’s Signature  ______________________________

Date

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Dignity Health
Center for Diabetes Management

Place Patient Identification Label Here

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