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

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 _____

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 wthin the last year ? ☐ Yes ☐ No

Have you had a pneumonia vaccination? ☐ Yes ☐ No

Do you carry emergency diabetes identification? ☐ Yes ☐ No

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Medications

Please bring a list of all your mediations 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 to you take? (List type and amount of each insulin)

Time	Morning	Noon	Dinner	Bedtime
Insulin				
Dose				

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 _____

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Health History continued

Do you have any of the following?

____ Stomach problems, (bloating, fulling full)

____ Changes in appetite or weight

____ Numbness, pain or tingling in the feet

____ Constipation

____ Any sores that will not heal

____ Diarrhea

____ Feeling tired or weak

____ Personality changes

____ Sexual problems Would you like information? ☐ Yes ☐ No

For Women

Are you pregnant now? ☐ Yes ☐ No Are you planning a pregnancy? ☐ 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. _____

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Medication Reconciliation (per patient)

Allergies and Adverse Reactions:

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

Medication	Dose	Frequency	Discontinued Date / Initial

Patient's Signature **Date**

Educator's Signature **Date**

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Medication Reconciliation (per patient), continued

Medication	Dose	Frequency	Discontinued Date / Initial Office use only

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