

# 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 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 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 \_\_\_\_\_



**Dignity Health**  
Center for Diabetes Management

Place Patient Identification Label Here

## Health History continued

Do you have any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Stomach problems, (bloating, fulling full) | <input type="checkbox"/> Changes in appetite or weight                               |
| <input type="checkbox"/> Numbness, pain or tingling in the feet     | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Any sores that will not heal               | <input type="checkbox"/> Diarrhea  |
| <input type="checkbox"/> Feeling tired or weak                      | <input type="checkbox"/> Personality changes   |
| <input type="checkbox"/> Sexual problems                            | Would you like information? <input type="checkbox"/> Yes <input type="checkbox"/> 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. \_\_\_\_\_

Place Patient Identification Label Here



