VIRGINIA HOSPITAL CENTER

Adult Diabetes Self-Assessment

Name:	**Date of Birth:** **Age:**
Address: _____ _____ _____	**Home phone:** **Cell phone:** **Work phone:** **Email:** **Best way to contact you:[ ]Home [ ]Cell [ ]Work [ ]Email** **Referring Doctor :**

Height: _____ Current Weight:_____ Goal Weight: _____

Has your weight changed in the past year?
[ ] No [ ] Yes How much? _____ [ ] Gain [ ] Loss

Type of Diabetes: [ ]Type 1 [ ]Type 2 [ ]Pre-Diabetes [ ] Gestational Diabetes [ ] Don't Know

Year/Age of Diabetes Diagnosis? _____/_____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ]Separated

How many people live in your household other than yourself? _____
Do you have any children? Ages? _____
If female: (Please circle)
Are you pregnant? [ ] No [ ] Yes
Are you considering pregnancy? [ ] No [ ] Yes

Race/Ethnicity (check all that apply)
[ ] White [ ] Native American [ ] Black or African American [ ] Multi-race
[ ]Asian [ ] Hispanic/Latino [ ] Native Hawaiian or other Pacific Islander

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? [ ] No [ ] Yes Please describe:

Preferred Language : [ ] English [ ] Other (please state) _____

What level of schooling have you completed?
[ ] Elementary [ ] High School Diploma [ ] Some College [ ] College/University Degree
[ ] Technical [ ] Military Training [ ] Graduate School [ ] Other:

Are You Employed: [ ] No [ ] Yes Occupation/Retirement status:

Have you had diabetes education? [ ] No [ ] Yes How long ago?

Do you have specific educational needs? [ ] No [ ] Yes ***** What kind?

How do you learn best: [ ] Listening [ ] Reading [ ] Observing [ ] Doing

From whom do you get support for your diabetes? [ ] Family [ ] Co-workers
[ ] Healthcare providers [ ] Support groups [ ] Social Media [ ] No one

In your own words, what is diabetes?

In the past 6 months have you gone to the emergency room? [ ] No [ ] Yes

In the past 6 monts have you been Admitted to the hospital? [ ] No [ ] Yes
Was the Emergency Visit or hospital admission diabetes related? [ ] No [ ] Yes

Do you have a history of the following (check all that apply) ?

[ ] High blood pressure
[ ] Heart Disease
[ ] Abnormal lipids
[ ] Circulation problems
[ ] Numbness/Pain (hands/feet)
[ ] Foot problems
[ ] Depression
[ ] Sexual Problems
[ ] Thyroid disease
[ ] Eye or vision problems
[ ] Kidney disease
[ ] Skin
[ ] Dental or mouth problems
[ ] Liver Disease
[ ] Stomach or bowel problems
Other: _____

Family History:
[ ] Diabetes
List relatives:

Have you had a dilated eye exam in the past 12 months? [ ] No [ ] Yes
Date:_____
Have you had a flu vaccine in the past 12 months? [ ] No [ ] Yes
Date:_____
Have you had a foot exam from a doctor in past 12 months? [ ] No [ ] Yes **Date:_____**
Have you visited a dentist in the past 6 months? [ ] No [ ] Yes **Date:_____**

Nutrition and Lifestyle

What food planning methods have you followed in the past/currently following? (Check all that apply)

[ ] Calorie Counting
[ ] Carbohydrate Counting
[ ] Food pyramid/Healthy choices
[ ] Low Carbohydrate
[ ] No method taught
[ ] Other: _____

Any dietary restrictions? (Ex. Low sodium, gluten free, etc.)_____

Typical Day Schedule: Please fill in the times of your meals and snacks, provide us with the type and amount of food you eat, this will help develop your meal plan.

	Time	Typical Meals (Best example please)
Breakfast		
Morning snack		
Lunch		
Afternoon snack		
Evening meal		
Bedtime snack		

Do you have any food allergies? [ ] No [ ] Yes Please List _____
Do you have Lactose Intolerance? [ ] No [ ] Yes
Do you drink alcohol? [ ] No [ ] Yes Amount and times per week: _____
Do you use tobacco?

[ ] No [ ] Yes [ ] Quit If yes, would you like information about smoking cessation? [ ] No [ ] Yes
How many times per week do you exercise? [ ] 0 [ ] 1-2 [ ] 3-4 [ ] 5-6 [ ] more than 6 **What type of exercise?**
If you do exercise, for how many minutes do you exercise? [ ] 1-10 [ ]11-15 [ ]16-30 [ ]More than 30
List your Oral Diabetes Medications/Non-Insulin Injectable: (Please include the dose and time of day that you take medicine) **How often do you take your diabetes medicine as prescribed?** [ ] Never [ ] Seldom [ ] Half the time [ ] Often [ ] Always
List all other medications, including over-the-counter medications and vitamins:
Do you have medication allergies? [ ] No [ ] Yes *****What Kind?

Insulin (Please list the insulin you are taking, include current dose and time of day)

Type of Insulin/ Dose of Insulin	Breakfast	Lunch	Dinner	Bedtime

If you take insulin, please answer the following, **if not** skip to Blood Glucose Monitoring:

Are you using an insulin to carbohydrate ratio? [ ] No [ ] Yes What is the ratio? _____ Units of insulin per_____grams of carbs
Do you supplement with extra insulin when your blood glucose is high (sliding scale)? [ ] No [ ] Yes How much extra insulin do you take?_____
Where do you inject your insulin?
Where do you store unopened insulin?
Where do you store the insulin you are using?
Do you use an insulin pen? [ ] No [ ] Yes
Where do you dispose of needles/syringes/lancets?
How often do you take your insulin as prescribed? [ ] Never [ ] Seldom [ ] Half the time [ ] Often [ ] Always

Blood Glucose Monitoring

Are you testing your blood sugar? [ ] No [ ] Yes	What type of meter do you use?
How many times of day do you test?	What is your typical or usual blood sugar range?
What is your A1C?	

In the last month how often have you had a low blood sugar? [ ] Never [ ] Once [ ] One or more times/week	How did you treat your low blood sugar?
	Do you wear medical ID? [ ] No [ ] Yes

Concerns

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
How do you handle stress:
What do you feel are your most important concerns in regards to managing your diabetes?
What is hardest for you in caring for your diabetes?
What are your thoughts or feelings about this issue (i.e. frustrated, angry, guilty)?
What would you like to learn from this program?

Patient Signature: _____Date: _____

****Please do not write below this line****

Clinician Assessment Summary

Education Needs/Education Plan: □[ ] Diabetes Disease Process [ ]Nutritional Management □[ ] Physical Activity [ ]Using Medication □ [ ]Monitoring □ [ ]Preventing Acute Complications □[ ] Preventing Chronic Complications □ [ ] Behavior Change Strategies □[ ] Risk Reduction Strategies □[ ] Psychosocial adjustment

Date: _____ Clinician Signature: _____