Diabetes Self- Assessment

ROCKLAND ENDOCRINE AND DIABETES SERVICES

Demographics

Name_____Date_____
Race_____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed
Have you ever attended diabetes classes? ☐ No ☐ Yes
If yes, name, location(s) and date(s)
Was it billed to Medicare? ☐ No ☐ Yes

Medical/Physical History

How confident are you in completing medical forms by yourself?
☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ Not at all, I need assistance
What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ don't know
How long have you had diabetes?
☐ Newly Diagnosed or _____**months** or _____**years**

Your Height_____ inches **Weight** _____ lbs. **Your Desired weight** _____ lbs.
Have you recently lost or gained? ☐ **None** ☐ **Lost** ☐ **Gained** How much? _____(lbs)

Do you exercise? ☐ **No** ☐ **Yes**
How many **days a week?** _____ **What kind** of exercise? _____
How many continuous minutes do you exercise at a time?
_____
How many hours do you spend sitting on an average day?
☐ 1 – 4 ☐ 5-8 ☐ 9-12 ☐ over 12 hours

Do you have:	**No**	**Yes**	**Describe**
Eye Disease			
Heart Disease			
High blood pressure			
Kidney Disease			
Obstructive Sleep Apnea			
Frequent infetions			
Foot Problems			
Pain, numbness			
Burning in feet,legs			

List any other medical problems or physcial limitations you have (gastric By-pass surgery, cancer, stroke, high cholesterol, thyroid, etc). _____

After correction (example: glasses, hearin aids, etc.), dou you have problems with any of the following:
☐ Seeing ☐ Hearing ☐ Reading ☐ Writing ☐ None

Diabetes Management

Do you test and keep a record of your blood sugars? ☐ No ☐ Yes
(*If you have not begun to check your blood sugar, you may skip to **Lifestyle.)***
How often do you test? _____/day **OR** _____/week (*fill in only 1)*
In relation to what you eat, what time of day do you test?
_____
_____

In the past 2 week: What was your **highest** blood sugar? _____
What was your **lowest** blood sugar? _____
What is the **name** of your blood sugar meter? _____

Lifestyle

Do you work outside of the home? ☐ No ☐ Yes Usual hours? _____
What **type of work** do you do? _____

Is your stress level: ☐ Low ☐ Medium ☐ High
Do you have financial problems that make it hard to buy food, supplies or medications?
☐ **No** ☐ **Yes**
Do you have people who can help when you need emotional and financial support?
☐ **No** ☐ **Yes**
In the past month have you often felt **depressed, down, hopeless?**
☐ **No** ☐ **Yes**
Does any of the following interfere with your health care?
☐ **Family life** ☐ **Work** ☐ **School** ☐ **Money** ☐ **Sexual** ☐ **Travel** ☐ **None**
How would you rate your sleep?
☐ **Excellent/No Problems** ☐ **Good** ☐ **Fair/Some Problems** ☐ **Terrible**
How many hours of uniterrupted sleep do you get?_____

Do you smoke? ☐ **Never** ☐ **Quit** how long ago?_____ ☐ **Yes** How much a day?_____
Do you drink alcohol? ☐ **No** ☐ **Yes** **Number of drinks per week?** _____

Diet

Do you follow a special meal plan for your diabetes? ☐ No ☐ Yes
Do you follow a modified meal plan? ☐ No ☐ Yes
☐ **Low Sugar** ☐ **Low salt** ☐ **Low fat** ☐ **High/Low(circle) protein** ☐ **Low carbohydrate**
☐ **Reduced Calorie** ☐ **Lactose Free** ☐ **Gluten Free** ☐ **Vegetarian(type)_____**
☐ **Other _____**

Do you usually **eat at the same time** each day? ☐ No ☐ Yes

How many meals do you eat daily?_____**How many snacks?**_____
Who prepares your meals?_____
How many meals a week do you eat **away from home?** _____
Where would you eat them?_____
What liquids do you drink? And how much of each?_____
_____

Food Log (write down what you would **eat on a typical day)**		
Breakfast Time:	Lunch Time:	Dinner Time:
Snack	Snack	Snack

Please provider information about your needs, beliefs, attitudes or behaviors that may be helpful for the diabetes educators: _____

_____

What are your feelings about your health and diabetes? _____

_____

Make a mark on the line that shows your readiness to change behaviors to improve diabetes.

Not prepared ⟷ Already changing

Medications for treatment of <u>Diabetes</u>

(Include over-the-counter vitamins, minerals, supplements and herbal)

Name of Medication	Amount taken	Time taken in relation to meals

If more space is needed, please use reverse side of page.

Patient Signature: _____ Date: _____

Reviewed by:_____ Date:_____