MUNSON HEALTHCARE
Diabetes Education

Diabetes Self-Assessment

General Information:

Name: _____ Birth Date: _____ Date: _____

Name you would like to be called: _____ E-mail address: _____

****E-mail address will not be shared and will be used for follow up contact or sending event notices*

Phone: (Home) _____ (Cell) _____ (Work) _____

Race: ☐ White ☐ Native American ☐ Hispanic ☐ African American ☐ Asian ☐ Other

Who lives with you? _____

Do you have any religious or cultural practices or beliefs that may affect how you care for your diabetes?

☐ Yes ☐ No If yes, please explain: _____

Social:

Are you currently employed? ☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Student

Type of job and work hours: _____

What is the last grade of school you completed? _____

How do you learn best? (Check **all** that apply)

☐ Reading ☐ Listening ☐ Individual Discussion ☐ Group Discussion ☐ Seeing/Visual ☐ Doing

☐ Watching Videos/TV ☐ Computer ☐ Other: _____

Check if any of these may affect your learning:
☐ Hard of Hearing ☐ Poor Vision ☐ Trouble Reading ☐ Memory Problems ☐ Learning Difficulty
☐ Do not speak English ☐ Other: _____

Does your insurance cover **all** or part of**: (**Call your insurance for this information)**

☐ Health care provider visits ☐ Diabetes Education ☐ Diabetes medications/insulin ☐ Supplies

☐ Meter ☐ Strips ☐ Lancets

If you have no insurance, can you pay for these things? ☐ Yes ☐ No

Medications:

List **All** medications: Include those needing a prescription and not needing a prescription.

- For example: Over the counter - Aspirin, Tylenol, Motrin, Cough/Cold Medicines

Medication allergies:

Name of Medication	Amount/How often?	What is it for?
☐ See attached list		

List **All** supplements: Include vitamin, mineral, herbal, or dietary supplements.

Name of Supplement	Amount	What is it for?

Medical History:

Have you ever or do you now have any of the following:

☐ Heart Problems ☐ Nerve Problems ☐ Vision Problems ☐ Arthritis ☐ High Blood Pressure

☐ Sexual Problems ☐ Depression/Anxiety ☐ High Cholesterol ☐ Skin Problems ☐ Osteoporosis

☐ Thyroid Disease ☐ Frequent Infections ☐ Kidney Problems ☐ Stomach/Bowel Problems

☐ Sleep Apnea ☐ Other/Explain: _____

List any major surgeries: _____

Diabetes History:

How long have you had diabetes? ☐ New ☐ 1-5 years ☐ 5-10 years ☐ Greater than 10 years

☐ Type 1 ☐ Type 2 ☐ Not sure

Have you had diabetes education in the past? ☐ Yes ☐ No If yes, year and where? _____

Pump type/model: _____ Glucose sensor/model: _____

Monitoring:

How often do you check your blood glucose? ☐ Once/day ☐ Twice/day ☐ 3-4/day

☐ Other: _____

Blood glucose range: Before meals _____to_____ Two hours after meals _____to _____

Do you ever have a low blood sugar reaction? ☐ Yes ☐ No If yes, ☐ Daily ☐ Weekly ☐ Other

How do you treat a low blood sugar? _____

Reducing Risks:

Tobacco use: ☐ Yes ☐ No ☐ Quit/how long ago _____ ☐ Want to quit ☐ Do not want to quit

Check any of the following exams you have had in the last year by a healthcare professional:
☐ Dilated Eye ☐ Foot ☐ Dental ☐ Urine Test for Protein

Check any of the following vaccines you have had:

☐ Flu Vaccine ☐ Pneumonia ☐ Hepatitis B ☐ Shingles

Have you had a visit to the emergency room or been hospitalized for low or high blood sugars within the last year? ☐ Yes ☐ No

For women of child-bearing age only: Are you planning on becoming pregnant? ☐ Yes ☐ No

Birth control ☐ Yes ☐ No ☐ N/A

Healthy Eating:

Height: _____ Weight: _____ Most comfortable weight: _____

Have you experienced a recent weight change? ☐ Yes ☐ No Was this change expected? ☐ Yes ☐ No

Have you ever seen a dietitian for diabetes? ☐ Yes ☐ No If yes, when? _____

Are you following a special diet? ☐ Yes ☐ No If yes, what kind? _____

How many meals do you eat daily? ☐ 1 ☐ 2 ☐ 3 How many snacks daily? ☐ 1 ☐ 2 ☐ 3

What beverages do you drink daily? ☐ Water ☐ Juice ☐ Pop ☐ Diet drinks ☐ Coffee ☐ Tea

How often do you drink alcohol? ☐ Never ☐ Daily ☐ 2-4 times/week ☐ Once a week ☐ Once a month

Do you have any food allergies? ☐ Yes ☐ No Type of allergy: _____

How often do you eat out or bring home "take out"? ☐ Never ☐ Daily ☐ Weekly ☐ Monthly

Do you have any chewing or swallowing problems? ☐ Yes ☐ No

Can you afford your food? ☐ Yes ☐ No

Being Active:

Do you exercise? ☐ Yes ☐ No My exercise routine is: ☐ Easy ☐ Moderate ☐ Intense

Do you have pain that interferes with your daily activity or exercise? ☐ Yes ☐ No

If yes, describe: _____

Coping:

Do you feel safe in your home? ☐ Yes ☐ No

What is your current stress level?

Not stressed ---------- Somewhat ---------- Very stressed

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

How do you handle things that worry you? _____

My diabetes is an: ☐ Opportunity ☐ Challenge ☐ Problem ☐ Burden ☐ Disaster ☐ Other

What concerns you the most about your diabetes?

How interested are you in learning about diabetes?

Not interested ---------- Somewhat ---------- Very interested

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please check all topics below that you would like to learn about		Educator recommendation	Education plan agreed upon
General Explanation of Diabetes	☐	☐	☐
Being Active	☐	☐	☐
Monitoring	☐	☐	☐
Medications	☐	☐	☐
Problem Solving (High and Low Blood Sugar)	☐	☐	☐
Healthy Eating	☐	☐	☐
Coping	☐	☐	☐
Reducing Risks	☐	☐	☐
Goal Setting	☐	☐	☐
Pre-pregnancy/Pregnancy Planning	☐	☐	☐
Injection Therapy	☐	☐	☐
Pump Therapy	☐	☐	☐
Glucose Sensor Therapy	☐	☐	☐
Other:	☐	☐	☐

Is there anything else you would like us to know?

Educator comments (notes of clarification elsewhere are to be dated/initialed)

Reviewed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

Reviewed by: _____ Date/Time: _____

Food Log

Your Typical Food Intake for One Day

	Amount of Food Ex. 1 cup, 1 slice, 3 oz., etc.	Detailed Description of All Food Eaten in 1 Typical Day Ex: skim milk instead of "milk", baked chicken instead of "meat"
BREAKFAST Time:		
SNACK Time:		
LUNCH Time:		
SNACK Time:		
DINNER Time:		
SNACK Time:		