MUNSON HEALTHCARE
Diabetes Education

Prediabetes 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 prediabetes?

☐ 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 ☐ Group Discussion ☐ Seeing/Visual ☐ Doing ☐ Watching Videos

☐ 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 _____

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 ☐ Asthma

☐ High Cholesterol ☐ Skin Problems ☐ Osteoporosis ☐ Thyroid Disease

☐ Frequent Infections ☐ Kidney Problems ☐ Stomach/Bowel Problems ☐ Sleep Apnea

☐ Other/Explain: _____

List any major surgeries: _____

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

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

Name of Medication	Amount/How often?	What is it for?

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

Name of Supplement	Amount	What is it for?

Healthy Eating:

Height _____ Weight _____ Most comfortable weight _____

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

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

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? _____

How interested are you in learning about prediabetes?

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

1 2 3 4 5

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:_____

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:		