LOMA LINDA UNIVERSITY
MEDICAL CENTER
Diabetes Treatment Center

Diabetes Self-Management Questionnaire

Name: _____ **Date:** _____

Date of Birth: _____/_____/_____ **Gender:** ☐ F ☐ M

Address:

_____

Street City State Zip

Phone: Home (____) _____ **Work: (___)** _____ **Mobile: (____)** _____

Ethnic Background: ☐ White/Caucasian ☐ Black/A-A ☐ Hispanic
☐ Native American ☐ Middle-Eastern ☐ Asian

Diabetes History

What type of diabetes do you have: ☐ type 1 ☐ type 2 ☐ Pre-diabetes
☐ Gestational ☐ Don't Know

In your own words, what is diabetes? _____

Monitoring Blood Glucose

Do you check your blood sugars: ☐ Yes ☐ No

Blood sugar range: (low)_____ **/ (high)**_____

How often: ☐ Once a day ☐ 2 or more/day ☐ l or more/week ☐ Occasionally

Acute Complications

Low Blood Glucose:

In the last month, how often have you had a blood sugar less than 70?

☐ Never ☐ Once ☐ 2 or more times/week

How do you treat your blood sugar?_____

High Blood Glucose:

In the last month, how often have you had a blood sugar more than 180?

☐ Never ☐ Once ☐ 2 or more times/week

Medications

Do you take diabetes medications: ☐ Yes (check all that apply below) ☐ No

☐ Metformin (Glucophage) dose: _____ ☐ Glyburide dose: _____

☐ Glipizide dose: _____ ☐ Sitagliptin (Januvia) dose: _____

Other diabetes pills name(s) & dose: _____ _____ _____ _____

☐ Insulin name(s) _____ dose(s) _____ when _____

☐ Insulin name(s) _____ dose(s) _____ when _____

Do you take Coumadin (warfarin) or any other blood thinner? ☐ No ☐ Yes

Name:_____

Psychosocial Well Being

My level of stress is: High ☐ Medium ☐ Low ☐ No stress ☐
How do you handle stress?_____
Have you been diagnosed with Depression? ☐ Yes ☐ No
How do you deal with your feelings of depression? ☐ Medication ☐ Therapy ☐ Support from family/friends
From whom do you get support for your diabetes? ☐ Family ☐ Co-Workers ☐ Healthcare Providers ☐ Support Groups ☐ No-one ☐ Other_____

Nutrition

Do you have any dietary restrictions: ☐ Salt ☐ Fat ☐ Fluid ☐ None

☐Other _____

How many meals do you eat in a day? 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ More ☐

Physical Activity

Do you exercise regularly? ☐ No ☐ Yes Type:_____
How often (times per week): _____Duration (minutes): _____

Chronic Complications

Do you have the following: ☐ Eye problems ☐ Kidney problems ☐ Numbness/tingling/loss of feeling in your feet ☐ Dental problems ☐ High blood pressure ☐ High cholesterol ☐ Sexual problems ☐ Other: _____
In the last 12 months, due to diabetes, have you? ☐ used the emergency room ☐ been admitted to a hospital

Behavioral changes

From 1 to 5 what is your readiness to make life style changes to better manage your diabetes?
Not ready 0 1 2 3 4 5 Ready