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 ☐ 1 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