Diabetes Self-Management Questionnaire

Name: ________________________________________ Date: __________

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

Address:___________________________________________________________________________________

Phone: Home (___) __________________ Work: (___) __________________ Mobile: (___) ________________

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

What is your language preference: ☐ English ☐ Other:______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

How many people live in your household? _________ How are they related to you? ___________________

Are you currently employed? ☐ Yes ☐ No What is your occupation? ________________

How confident are you in filling out medical forms by yourself? ☐ Extremely ☐ Quite a bit ☐ Somewhat ☐ A little bit ☐ Not at all

How do you learn best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing

Do you have any difficulty with: ☐ hearing ☐ seeing ☐ reading ☐ speaking

Explain any checked: ________________________________

What is the last grade of school you have completed? _____________________________________________

Do you use computers: ☐ to email ☐ look for health and other information ☐ Shop

Diabetes History

Year/Age of Diabetes Diagnosis: _______________________/______________________________

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

Have you had previous instruction on how to take care of your diabetes? ☐ Yes ☐ No
If yes, How long ago? ________________________________

In your own words, what is diabetes? ________________________________

Height: _________ Weight: _________

Any weight changes (up or down)? ☐ Yes ☐ No ☐ Active Weight Loss? ☐ Yes ☐ No
If yes, please explain:________________________________________________________

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?
☐ Yes ☐ No Please describe:____________________________________________________

Checking 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

When: ☐ Before breakfast ☐ 2 hours after meals ☐ Before bedtime

Name of glucose meter:____________________________________________________________
Other Medical Concerns:
Do you have any of the following: ☐ eye problems ☐ kidney problems ☐ numbness/tingling/loss of feeling in your feet ☐ dental problems ☐ high blood pressure ☐ high cholesterol ☐ sexual problems ☐ depression ☐ other: ____________________________________________________

Please list any other medical conditions: __________________________________________________

Medications:
Do you take diabetes medications: ☐ Yes (check all that apply below) ☐ No
☐ Diabetes Pills name(s) & dose: ___________ ___________ ___________ ___________
☐ Insulin name(s) ___________________ dose(s) _____________ when _____________

Do you take your medications as prescribed? ☐ rarely ☐ sometimes ☐ most of the time ☐ always
Do you have prescriptions for diabetes medications that you have not filled? ☐ Yes ☐ No
Do you have any medication allergies? ☐ Yes ☐ No
If yes please list: ______________________________________________________________________

Do you take other medication? ☐ Yes ☐ No
If yes, please list all other medications: __________________________________________________

Do you take any over the counter medications, vitamins, or supplements? ☐ Yes ☐ No
If yes, please list all over the counter medications: _________________________________________

Low Blood Glucose
In the last month, how often have you had a blood sugar less than 70?
☐ Never ☐ Once ☐ One or more _______times/week
How do you treat your blood sugar? _____________________________________________________

Well Being:
My diabetes interferes with other aspects of my life: ☐ Agree ☐ Neutral ☐ Disagree
My level of stress is high ☐ Agree ☐ Neutral ☐ Disagree
I have some control over whether I get diabetes complications or not: ☐ Agree ☐ Neutral ☐ Disagree
I struggle with making changes in my life to care for my diabetes: ☐ Agree ☐ Neutral ☐ Disagree
How do you handle stress? ______________________________________________________________

From whom do you get support for your diabetes? ☐ Family ☐ Co-Workers ☐ Healthcare Providers
☐ Support Groups ☐ No-one ☐ Other ________________________________

What concerns you most about your diabetes? ______________________________________________
What is the hardest for you in caring for your diabetes? __________________________________

What are your most interested in learning from these diabetes education session(s):
☐ Diabetes disease process ☐ Nutrition Management ☐ Physical Activity ☐ Using medications
☐ Monitoring ☐ Preventing Complications ☐ Behavior Change Strategies ☐ Risk Reduction
☐ Psychosocial adjustments
**Meal Plan**

Do you have a meal plan for diabetes: ☐ Yes ☐ No  
If yes, please describe: ____________________________

Do you read and use food labels as a dietary guide:  ☐ Yes ☐ No

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

Give a sample of your meals for a typical day:

<table>
<thead>
<tr>
<th>Time: _______</th>
<th>Breakfast</th>
<th>______________________________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time: _______</td>
<td>Lunch</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Time: _______</td>
<td>Dinner</td>
<td>______________________________________________________________</td>
</tr>
<tr>
<td>Time: _______</td>
<td>Snack</td>
<td>______________________________________________________________</td>
</tr>
</tbody>
</table>

How much water do you drink daily? ________________________________ oz.

Do you: do your own food shopping? ☐ Yes ☐ No  
Cook your own meals? ☐ Yes ☐ No

How often do you eat out? _______________________________________

Do you have any food allergies? ☐ Yes ☐ No

**Physical Activity:**

Do you exercise regularly? ☐ No ☐ Yes  
Type: ____________________________

How often: ____________________________

My exercise routine is: ☐ easy  ☐ moderately intense  ☐ very intense

Sick Days/Complications:

Have you been given sick day guidelines? ☐ Yes ☐ No

Do you drink alcohol? ☐ No?  ☐ Yes Type: ____________________________ ☐ How many? _________.
☐ per day  ☐ per week  ☐ per Month  ☐ occasionally

Do you use tobacco? ☐ cigarette ☐ pipe ☐ cigar ☐ chewing ☐ none  ☐ Quit  How long ago? __________

In the last 12 months, have you: ☐ used the emergency room services ☐ been admitted to a hospital
Was the ER visit or hospital admission diabetes related? ☐ Yes ☐ No