SELF-ASSESSMENT QUESTIONNAIRE
Thank you for completing the questionnaire – please answer as best you can!

Name ___________________________________________ Age _________ □ Male □ Female

Occupation: ___________________________________________ □ Not working □ Retired from: ____________________________

Education: □ Some high school □ High school graduate □ Some college □ College graduate

Ethnic Background: □ Asian □ Black/African American □ Hawaiian/Pacific Islander
□ White- Hispanic □ White- non-Hispanic □ Other_________________________ □ Unknown

Living Situation: I live with □ Spouse/Partner □ Single/Live Alone □ Divorced/Separated □ Widow/Widower
□ Retirement Home □ Other: ____________________________________________

Does anyone help you with your healthcare needs? □ No □ Yes: ____________________________

Are there any issues that would interfere with your ability to learn? □ No □ Yes
If yes, (please select): □ Visual □ Hearing □ Reading □ Language □ Cognitive □ Other: ______________

Are there any language, religious or cultural factors to consider in teaching you? □ No □ Yes
If yes, please explain: ___________________________________________________________________

Learning Preference (check all that apply): □ Demonstration □ Reading/Handouts □ Class □ Computer

Please provide email address to receive our monthly newsletter (optional): ______________________________

MEDICAL HISTORY

Height: _____ ft. _____ in.  Weight: ________ lbs.  Do you have a preferred weight? __________ lbs.

Has your weight changed recently? □ No □ Yes  If yes, how many lbs. gained/lost? __________ lbs.

Have you ever participated in a weight loss program? ____________________________________________

Please select all current and former medical conditions or problems you have experienced:
□ High blood pressure  □ High cholesterol  □ Heart problems  □ Circulation problems
□ Stroke/TIA  □ Thyroid  □ Kidney / Liver  □ Gastrointestinal problems
□ Foot/nerve problems  □ Depression  □ Other psychiatric  □ Eye problems
□ Gum problems  □ Other: ____________________________________________
□ History of infection or non-healing wound: __________________________________________

Please select any of the following you’ve had in the last year:
□ Medical check-up  □ Dental check-up  □ Dilated eye exam  □ Foot exam  □ Psychotherapy
□ Kidney Function (urine protein test)  □ Annual flu vaccination  □ Pneumonia vaccination

List any major operations / recent hospitalizations: ____________________________________________
YOUR DIABETES HISTORY

What is your most recent A1C result?  A1C______%  Approx. date: _____________  □ Not sure/don’t know
How long have you had diabetes? ________________________________________________________
Do you have any relatives with diabetes?  □ No  □ Yes: _______________________________________
What type of diabetes do you have?  □ Type 2  □ Type 1  □ Don’t know
How would you rate your understanding of diabetes?  □ Excellent  □ Good  □ Fair  □ Poor
Have you had any previous diabetes education?  □ No  □ Yes  If yes, when? ____________________
Do you have a history of hospitalization related to diabetes? _________________________________
How do you feel about having diabetes? __________________________________________________
What is your main reason for coming today? ________________________________________________

MONITORING YOUR BLOOD SUGAR

Do you test your blood sugar?  □ No  □ Yes  If yes, which meter do you use: ___________________
How often do you test?  □ Occasionally  □ Every few days  □ Daily  □ Multiple times per day
What time(s) of day do you test? __________________________________________________________
Do you ever have low blood sugar events?  □ No  □ Not sure  □ Yes, how often? ________________
Do you have symptoms when low?  □ No  □ Yes (describe) _________________________________
Is your blood sugar ever over 200mg/dl?  □ No  □ Not sure  □ Yes, how often? ________________
Do you have symptoms when high?  □ No  □ Not sure  □ Yes (describe) _______________________

MEDICATIONS

In the last two months, have you skipped/forgotten to take your medication?  □ Yes  □ No
If yes, list the reasons (check all that apply): □ Forgot  □ Financial  □ Ran out  □ Side effects
Do you carry a list of your medications?  □ Yes  □ No
Do you wear an insulin pump and/or continuous glucose monitor?  □ Yes  □ No
If yes, list the type(s): _________________________________________________________________
Please list all prescribed medications you take:
1) _______________________________ dosage __________________ frequency
2) _______________________________ dosage __________________ frequency
3) _______________________________ dosage __________________ frequency
4) _______________________________ dosage __________________ frequency
5) _______________________________ dosage __________________ frequency
NUTRITION

Do you follow a meal plan?  □ No  □ Yes  If yes, what type? ________________________________
Who does the cooking at your home? __________________ Who does the shopping? __________________
Do you have any problems purchasing food? □ No  □ Yes: _________________________________
Do you have problems chewing or swallowing your food? □ No  □ Yes: _________________________
Do you wear dentures? □ No  □ Yes  If yes, do they fit well? ________________________________
Do you have food allergies? □ No  □ Yes  If yes, please specify: ______________________________
Can you share what foods raise blood sugar? □ No  □ Yes  If yes, please list: __________________
How many meals a week do you eat out? □ 0 - 1  □ 2 - 4  □ 4 - 7  □ 8 or more
  List restaurants, fast food, etc. where you visit: _____________________________________________
Do you skip meals? □ No  □ Yes
  If yes, which meals do you tend to skip? □ Breakfast  □ Lunch  □ Dinner  □ Other: _____________
How many meals do you typically eat each day? _____________ How many snacks do you eat? ___________
Please provide an example of a typical day of food/drink intake:
  Breakfast: ______________________________________________________________________________
  Snack: __________________________________________________________________________________
  Lunch: __________________________________________________________________________________
  Snack: __________________________________________________________________________________
  Dinner: __________________________________________________________________________________
  Snack: __________________________________________________________________________________
How do you feel about your food choices? □ Good  □ Needs improving  □ Not sure

ACTIVITY

Do you do physical activity on a REGULAR basis? □ No  □ Yes  How many times a week? ____________
  How long are you active? □ 1 – 30 min  □ 31 – 60min  □ 60+ min
What type of activity do you do? _____________________________________________________________
  Do your break a sweat? □ Yes  □ No
  Does your heart rate increase? □ Yes  □ No
Are there any medical reasons that limit/stop you from daily activity? □ Yes  □ No
  If yes, please explain: _____________________________________________________________________
LIFESTYLE

Do you use tobacco? □ No □ Yes  If yes, what type? __________Amount _____ per day/week (circle one)

Have you tried to quit? □ No □ Yes  Do you have any interest in resources to stop smoking? □ No □ Yes

Do you drink alcohol? □ No □ Yes  If yes, what do you drink? ________________

Amount ______________________ per day/week/month (circle one)

How many hours of sleep each night do you get? __________  Sleep quality: □ Good □ Fair □ Poor

Rate the level of stress in your life: □ Low □ Medium □ High □ Very high

How do you cope with your stress? ______________________________

How would you rate your overall health? □ Excellent □ Good □ Fair □ Poor

YOUR LEARNING OBJECTIVES

Please mark all topics you are interested in learning about.

_____ What is diabetes (causes, diagnosis, symptoms)?

_____ Nutrition  _____ Healthy eating for diabetes

_____ Carbohydrate counting

_____ Individualized meal plan

_____ Physical Activity  _____ Activity for blood sugar control & weight loss

_____ Medications  _____ Medications usage & options

_____ Types of insulin & administration

_____ Insulin pumps

_____ Continuous glucose monitor

_____ Monitoring Blood Glucose  _____ Glucose meter usage & blood glucose targets

_____ How to understand your blood glucose readings

_____ Prevention of Complications  _____ High / low blood sugar range and what to do

_____ Understanding lab results (A1C, Cholesterol)

_____ Steps to prevent complications & illness

_____ Foot care and diabetes

_____ Traveling and diabetes

_____ Coping, Stress

_____ Setting and Reaching Goals

Anything else? _______________________________________________________________