Billings Clinic

Diabetes Self Management Assessment

Name:____Date:_______________________________

What type of diabetes do you have? Type 1_______ Type 2 _____Gestational ______Don't Know_______
When did you find out you had diabetes?____

History
Do you currently check your blood sugar at home? Yes_____ No ______ How often do you test your blood sugar?_____________________________ What is your usual blood sugar range?_______________________
Have you noticed a change in your blood sugars? Yes _____No______ If yes, explain_________________
____
Have you had any blood sugars below 70 mg/dl? Yes ______No________ If yes, how did you feel?________
____What did you do?___________________________________
Do you know what your last Hemoglobin A1C was? Yes _____ No_____ Result:_______________________
Do you have heart disease? Yes _______ No_______ Do you have high blood pressure? Yes_____No______
Have you had diabetes education in the past? Yes ____ No____ If yes, where?__________________________
Do you wear medical identification? Yes _____No_______

Medications
Do you take diabetes medications? Yes _____ No_______ If yes, what do you take? Pills ______
Insulin______ Combination of pills and insulin _____Byetta _____ Victoza _____ Symlin _______
How often do you miss taking your diabetes medication? ____
____
Is your medication list complete? Yes _______________No_________________
Please list any other medications/supplements that you take ____
____

Nutrition
What type of meal plan to you follow? (low sodium, low carb, low fat etc…) ___________________________
____
List any nutrition concerns you have ____
____
Is weight loss your goal? Yes _____No_______ If yes, at what weight do you feel your best at_____________

Physical Activity
Do you exercise regularly? Yes ______No _____ Type:____
How many days per week? ________________________________ How many minutes?_________________

Lifestyle/Health Behaviors
Do you smoke or chew tobacco? Yes ____ No _____If yes, do you have any plans to quit
_______________________Do you drink alcohol? Yes _____ No _____ If yes, how often and how much per week? ____

Diabetes Self Management Assessment (cont.)

Do you have a history of depression or anxiety? Yes ______No _______
Are you under any significant stress? Yes ____ No ____ If yes, how are you coping?______________________
____
From whom do you get support for your diabetes? Family _______ Co-workers _______ Friends ______Healthcare providers _______ Support Group ______ No one __________
Do you have adequate finances to allow for good diabetes care? Yes ______No _______
Do you have difficulty with: hearing ______seeing ______reading ______ speaking _______
How best do you learn? Listening ______ Reading _______ Observing ______ Doing_______
Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? Yes _____ No _______ If yes, please explain____
What are you most interested in learning from these diabetes education session?_________________________
____
In your own words what is diabetes? ____
What is your biggest challenge living with diabetes? ____
____
I feel overwhelmed by the demands of living with diabetes. Yes ______ No _______
I feel that I am often failing with my diabetes routine Yes _______No ___________
How motivated are you in making lifestyle changes? On a scale from 1 to 5, 1 is the least motivated and 5 being the most motivated, where are you? ____

Risk Reduction

When was your last dilated eye exam?_____________________By whom______________________________
How often do you see your healthcare provider? ____
How often do you see your dentist/dental hygienist?____
Do you examine your feet? Yes ____No ____ If yes, how often____
Who trims your toenails?_______________________Special/Feet concerns_____________________________
Are you experiencing any changes in sexual function?____
Date of flu vaccine_____________________ Date of last pneumonia vaccine___________________________
On average, how many hours of sleep do you get nightly?____
Do you feel rested when you wake up? Yes _________No ___________
Would you be interested in participating in a diabetes research study? Yes ______ No _______

Education Needs/Education Plan: Diabetes Disease process ______ Nutritional Management _______ Physical Activity ______ Using Medications ______ Monitoring ______ Preventing Acute Complications Preventing chronic complications ______ Behavior Change Strategies ______ Risk Reduction Strategies ______ Stress and Coping ______

Patient signature:_______________________________________Date/Time____________________________

Clinician signature:______________________________________Date/Time____________________________