Diabetes Treatment Center

DESERT SPRINGS HOSPITAL MEDICAL CENTER

A Member of The Valley Health System

Outpatient Diabetes Management Self Assessment

Name:_____ Date_____

Age:_____ Gender F /M Height_____ Weight_____ lbs/KG

What type of diabetes do you have? Type 1 ☐ Type 2 ☐ At risk for Diabetes ☐ Don't know ☐

When were you first diagnosed?_____

Are you taking Diabetic Medications? Y / N Oral Pills ☐ Insulin ☐ Other injectables ☐

List all Diabetic Medication you are currently taking: _____

_____

List all other medication you are taking including OTC and supplements: _____

_____

_____

Do you have support for your diabetes care? Y / N Family ☐ Friend ☐ Health Care Provider ☐

Support Group ☐ No one ☐ Other_____

Do you have diet restrictions? Y / N Salt ☐ Fat ☐ Fluid ☐ Protein ☐ Other_____

Please describe a typical meal for you _____

_____

_____

Do you read food Labels? Y / N Do you eat at regular times? Y / N

Who prepares your meals?_____

How often do you dine out a week? 0-1 2-4 5-6 More than 7

Do you smoke or use tobacco products? Y / N

Do you exercise regularly Y /N Type_____ How often_____

Do you have a meter to check your blood sugar? Y / N Type of meter_____

How often do you check you blood sugar? _____per Day/Week

Do you know what a low blood sugar is? Y / N Do you know how to treat a low blood sugar? Y / N

Do you have allergies to foods or medications? Y / N

If so, please specify_____

Name_____ Date:_____

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Do you have any of the following conditions?

If YES please explain below:

	N	Y		N	Y
Heart Disease	☐	☐	Sexual Dysfunction	☐	☐
Hypertension	☐	☐	Foot Problems	☐	☐
Vision Problems	☐	☐	Kidney Problems	☐	☐
Neuropathy	☐	☐	Dental Problems	☐	☐

_____

_____

_____

Do you have other health conditions? Y / N List all other health conditions: _____

_____

_____

Have you had any of the following tests/exams/vaccinations done?

	N	Y		N	Y
Flu Vaccine	☐	☐	Dental Exam	☐	☐
Pneumonia Vaccine	☐	☐	Comprehensive Foot Exam	☐	☐
Dilated Eye Exam	☐	☐	Kidney Function Tests	☐	☐
EKG Exam	☐	☐	Nerve Function Tests	☐	☐

Have you been hospitalized in the last 12 months? Y / N

If so, please specify: _____

_____

Do you have financial/resources concerns that will affect your ability to care for your diabetes? Y / N

Food ☐ Medications: ☐ Transportation ☐ Monitoring strips ☐

Other:_____

What are you most interested in learning about related to management of you diabetes?

_____

What is your greatest concern about your diabetes?

_____

For Women Only: Are you Pregnant Y / N Are you considering Pregnancy? Y / N

Information provided by_____ Date_____

Reviewed by:_____Date_____

(Office use only)

Revision Date 1/31/2014