Desert Springs Hospital Medical Center
A Member of The Valley Health System
Diabetes Treatment Center

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?________________ List relatives with diabetes: _______________________

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:________________

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	☐	☐
Depression	☐	☐			

____

____

____

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:____

Name___________________________________ Date:_________________

Educational Learning Needs Assessment

Have you participated in any diabetes education in the past? No______ Yes ______
If so, When/Where ____

Language Spoken/Preferred: *English* ____ *Spanish*_____ *Other* ____
Specify ____________________________________ Interpreter Services needed? Yes_____ No _____
Reading Preference: English____ Spanish____ Unable to Read ____
Other -describe____

Religious/Cultural Practices: Do you have any religious or cultural practices that may alter/impact your care/education? No ___ Yes ___ If so, please describe_____________________________

Physical Limitations: Do you have any physical limitations that may alter/impact your learning ability? Yes ___ No ____If so, describe____

Learning Preference: Do you have a preference for method(s) of learning? Yes ___ No ____
If so, please specify____

Barriers to learning (Vision/Auditory/Literacy/ Language **)**_______________________________________

How important is it to you to follow a diabetes self-management plan that works for you--
0 is not important and 10 is very important? (circle one) 0 1 2 3 4 5 6 7 8 9 10

How confident are you that you can follow a diabetes self-management plan that works for you-
0 is not important and 10 is very important? (circle one) 0 1 2 3 4 5 6 7 8 9 10

Do you have any stress in your life? Yes ___ No ___

How do you cope with stress? ____

____

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)