

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: _____

Do you have any of the following conditions?

If YES please explain below:

	N	Y
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>
Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>

	N	Y
Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Foot Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	Comprehensive Foot Exam	<input type="checkbox"/>	<input type="checkbox"/>
Dilated Eye Exam	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Function Tests	<input type="checkbox"/>	<input type="checkbox"/>
EKG Exam	<input type="checkbox"/>	<input type="checkbox"/>	Nerve Function Tests	<input type="checkbox"/>	<input type="checkbox"/>

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

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)