

Diabetes Self-Management Questionnaire

General Information

1. Name: _____ Age: _____ Date: _____
2. Address: _____ City: _____ Zip Code: _____
3. Home phone: _____ Work phone: _____ Cell: _____
4. Your primary physician's name: _____
5. Your diabetes physician's name: _____
6. What is your race or ethnic background?
 American Indian or Alaskan Native Asian/Chinese/Japanese/Korean Black/African American
 Hispanic/Latino/Mexican Native Hawaiian or other Pacific Islander White/Caucasian
 Other: _____

Socioeconomic / Support System

1. Marital status: Single Married Divorced Widowed
2. How many people live in your household? _____
3. Does anyone else who lives with you have diabetes? No Yes: Who? _____
4. Is there anyone who will help you with your diabetes care? Yes No
If "yes," who? _____
If different, who is your primary support person/caregiver? None Yes _____
5. Occupation: _____ Work hours: _____
6. Last grade of school completed: _____
7. Any religion preference? _____

Cultural Influences

1. Do you have any special dietary needs, religious and/or observances? Yes No
If "yes," explain: _____
2. What is your language preference? Spoken: _____ Reading: _____

Diabetes History

1. How long have you had diabetes or year diagnosed? _____
2. What type of diabetes do you have? Type 1 Type 2 Gestational Don't know

Chronic Complications- Are you aware of or have you ever been told by a doctor you have any of these problems? Please rate as: L=Little M=Moderate S=Severe

- Eye problems, explain: _____
- Heart/artery problems, explain: _____
- Nerve problems, explain: _____
- Teeth/gums problems, explain: _____
- Feet/leg problems, explain: _____
- Skin problems, explain: _____
- GI problems, explain: _____
- Sexual problems, explain: _____
- Kidney problems, explain: _____
- Frequent infections, explain: _____
- Other problems, explain: _____

Diabetes Health Attitudes / Learning

1. How would you rate your understanding of diabetes? Good Fair Poor
2. In your own words what is diabetes? _____
3. Have you ever been instructed on diabetes care? No Yes: Where and by whom?

4. Do you have any physical limitations that may affect your ability to perform your self-care?
 Hearing problems Problems with the use of your hands
 Vision loss (not corrected by glasses or contacts) Problems with the use of your feet
5. How do you learn best?
 Written materials Verbal discussions Video Hands-on/Doing
 Other _____

Medical History

- Have you ever been diagnosed, ever been told, or have you had problems with the following?
 High Blood pressure High Cholesterol/Triglycerides Kidney/Bladder problems
 Eye or vision problems Frequent nausea, vomiting, constipation, diarrhea
 Surgery in the last 5 years Heart disease/Chest pain Thyroid disease
 Asthma Depression or anxiety Circulation problems
 Obesity Shortness of Breath Stroke

 Numbness/pain/tingling of hands/feet Other health problems: _____
- Do you have any allergies? No Yes: Medication/foods: _____
- Do you smoke? No Have you ever smoked in the past? _____
 Yes: How long did you smoke for? _____ How much? _____
For how long? _____ When did you quit? _____
Have you ever tried to quit? No Yes: How long ago? _____
Would you like information on how to quit? _____
- Do you drink alcohol? Yes No If "yes," amount and type? _____

Women Only

- Date of last Pap smear: _____ Last mammogram: _____
- How many pregnancies have you had? _____ Abortions/miscarriages: _____
- How many living children do you have? _____ Complications of pregnancy? _____
- Were you ever told you had diabetes in pregnancy? Yes No
- Did you have any children that weighted over 9 pounds at birth? Yes No
- What method of birth control do you use?
 No method is used Postmenopausal Birth control pills Condoms
 Norplant Tubal ligation Depo-Provera shots IUD

Women Only: Pregnancy

- Are you currently pregnant? Yes No If "yes," what is your due date? _____
- When was your last menstrual period? _____
- Are you planning to become pregnant? Yes No
If "yes," are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes? Yes No

Family History

- List any family members with diabetes: _____
With high blood pressure: _____
With heart attacks or other heart problems: _____
With stroke: _____ With cancer: _____

Health Care Used in Past 12 months

1. When was your last physical examination? _____
2. How often do you see your regular doctor? _____
3. Have you been hospitalized within the last 12 months? Yes No
If "yes," describe reason(s) and where: _____
4. Have you been to the emergency room within the last 12 months? Yes No
If "yes," describe reason(s) and where: _____

Your Diabetes Self Care Behaviors

Healthy Eating

1. Height: _____ Weight: _____ What weight are you comfortable at? _____
2. Has your weight changed in the past three months? Yes No If "yes," I've lost / gained _____ lbs.
Was the weight change intentional? No Yes: _____
3. Have you ever received diet counseling? No Yes If "yes," describe: _____
4. Do you have a current meal plan? _____ If so, what is it? _____
5. What is your biggest challenge to eating healthily? _____
6. How many times do you eat per day? Meals: _____ Snacks: _____
7. Times of meals: am: _____ noon: _____ pm: _____ snacks: _____
8. How often do you eat/drink (answer **per day** or **per week**):
 Fruit: _____ Juice: _____ Milk: _____ Fat-free 1 % 2 % Whole
 Vegetables: _____ Cheese: _____ Sweets: _____ Sugar-free desserts/drinks: _____
Beverages with sugar: _____ Alcohol: _____ Water: _____ How much a day? _____
Starches eaten: State number of servings eaten **per meal**
 Bread: _____ Potatoes: _____ Beans: _____ Tortillas: _____ Rice: _____
 Pasta: _____ Corn/Peas: _____ Other: _____
Meats/Proteins: State number of times eaten **per week**
 Chicken: _____ Red Meats: _____ Fish: _____ Turkey: _____
 Pork: _____ Eggs: _____ Cheese: _____ Other: _____
Cooking Oil/Fat used: Lard/Shortening: _____ Butter/Margarine: _____ Olive: _____
 Vegetable/Corn: _____ Canola: _____ Peanut: _____ Other: _____
9. Who does the cooking? _____ Who usually does the grocery shopping? _____

10. How many times during the week do you eat away from home? _____
11. How often is your meal away from home: Cafeteria style: _____ Fast food: _____ Buffet: _____
 Sit-down restaurant: _____ Other: _____
12. How is your food usually prepared? Fried Baked Broiled Grilled Steamed
13. How would you describe your portions? Small Average Large
14. How would you describe your appetite? Increased Normal Decreased
15. List any food allergies or intolerance: _____

16. Any other special diet needs: _____

17. How do mood/stress affect your eating? _____

Being Active

1. Do you exercise regularly? Yes No Types of exercise(s): _____
 How often do you exercise? _____ How long each time? _____ What time of day do you exercise? _____
2. List any problems with exercise: _____
3. How important is it to you to be active, where **0** is not important at all and **10** is very important?
 0 1 2 3 4 5 6 7 8 9 10
4. How sure are you that you can be active, where **0** is not sure and **10** is very sure?
 0 1 2 3 4 5 6 7 8 9 10

Monitoring

1. Do you test your blood for sugar? Yes No
 If "yes," what blood sugar monitor do you use? _____
 Do you have any problems with your monitor? No Yes _____
 How often do you test? Once a day 2 or more times a day Once/ Twice a week Rarely/ Never
 Usual results? Mornings: _____ Afternoon: _____ Bedtime: _____ After Meals: _____ Other times: _____
2. Do you keep a record? Yes No
3. What is considered a normal blood sugar range? _____
4. What are **your** target numbers? _____
5. How often do you have **HIGH** blood sugar? (250 or more) Daily Several times a week
 A few times a month Once in a while Rarely or never Don't know
6. How often do you have **LOW** blood sugar (70 or less)? Daily Several times a week

A few times a month Once in a while Rarely or never Don't know

7. Do you have access to your diabetes supplies? No Yes: Pharmacy _____

8. Do you test your urine for sugar or ketones? No Yes: How often _____

9. How important is it to you to monitor your blood sugar at least once per day, where **0** is not important at all and **10** is very important?

0 1 2 3 4 5 6 7 8 9 10

10. How sure are you that you can monitor your blood sugar at least once per day, where **0** is not sure at all and **10** is very sure?

0 1 2 3 4 5 6 7 8 9 10

Taking Medications

1. Do you take pills for your diabetes? No Yes: What times? _____

2. Any side effects from the medications that you know of? No Yes: _____

3. Do you take any additional nutritional supplements? Vitamins Herbal supplements

Other: _____

Have you ever forgotten to take your diabetes medication? No Yes: How often? _____

4. If you take insulin: Do you inject insulin with: Syringe Insulin pen Insulin pump

Who fills the syringe? _____ Who gives the injection? _____

What injection sites are used? _____

Where do you keep the insulin? _____

Do you reuse your syringes? No Yes If "yes," how often? _____

Where do you dispose your syringes? _____

5. Have you ever forgotten to take your insulin? No Yes: How often? _____

6. How important is it to you to take your medicines, where **0** is not important at all and **10** is very important?

0 1 2 3 4 5 6 7 8 9 10

7. How sure are you that you can take your medicines, where **0** is not sure at all and **10** is very sure?

0 1 2 3 4 5 6 7 8 9 10

Problem Solving

1. Have you ever had a low blood sugar reaction? No Yes

If "yes," how did you feel? _____

How did you treat it? _____

Did you require assistance or hospitalization for it? No Yes: _____

2. Do you carry a source of sugar with you? No Yes If "yes," what kind? _____

3. Have you ever had to give Glucagon? Don't Know No Yes

4. Does someone who lives with you know how to give Glucagon? Don't Know Yes No
5. Do you have an identification that says you are diabetic? Don't Know Yes No
6. Have you ever had high blood sugar?? Don't Know Yes No

If "yes," how did you feel? _____

What did you do to treat it? _____

Have you ever been hospitalized for very high blood sugar? No Yes

When/Where: _____

7. When you are sick or cannot eat usual food, how do you take care of yourself?
- Replace usual food with carbohydrate or sugar Take diabetes medication Check ketone levels
- Check blood sugar more often Drink more water Contact healthcare provider
- Do nothing Other: _____

Stress

1. Is there much stress in your life? No If "yes," explain: _____
2. What do you do to handle stress in your life? _____
3. How important is being able to problem solve when being faced with everyday and/or challenging decisions, where **0** is not important at all and **10** is very important?
- 0 1 2 3 4 5 6 7 8 9 10
4. Do you feel you can problem solve when faced with everyday and/or challenging decisions, where **0** is not sure at all and **10** very sure?
- 0 1 2 3 4 5 6 7 8 9 10
5. Do you perceive problems with your diabetes management, where **0** is none perceived and **10** is perceive many?
- 0 1 2 3 4 5 6 7 8 9 10

Healthy Coping

1. How would you describe your general health? Good Fair Poor
2. Is your health important to you? All the time Sometimes Only when ill Not at all
3. How do you feel about having diabetes? _____
4. Do you feel diabetes is serious? Yes No
5. Do you feel you can control your diabetes? Yes No
6. Is good control worth it? Yes No
7. My diabetes has caused problems in the following areas: Family life/social activities Work/school
- Sports/exercise Sexual relations Finances Contentment Travel
- Other: _____
8. Are you currently experiencing any of the following?
- Separation Divorce No problems Recent death
- Financial difficulties Housing problems Illness Unemployment
- Depression symptoms Loneliness Confusion
- Thoughts of hurting yourself Other: _____

9. Do you have history of depression? No Yes: How often do you feel depressed?
 A lot Some A little Not at all

Reducing Risks

- How often do you have your eyes checked by an eye doctor? _____ Date of last exam (with drops in the eyes): _____
- Do you wear glasses? No Yes: For what? _____
- Have you noticed any changes in your skin recently? Yes No
If "yes," please describe: _____
- How often do you check your feet at home? Daily Weekly Never Other: _____
Date of last foot exam by doctor: _____
- How often do you have a dental checkup? _____ Date of last checkup: _____
- Have you ever had a shot to prevent pneumonia? No Yes: When: _____
- Have you received a flu shot within the year? No Yes: When: _____
- Have you had your blood pressure checked? No Yes: When: _____
- Have you had a fasting glucose (blood sugar) checked? No Yes: When: _____
- Have you had your cholesterol and triglycerides checked? No Yes: When: _____
- Have you had an A1c test done? No Yes: When: _____
- Do you wear a bracelet or keep something with you that identifies you as having diabetes? Yes No
- How sure are you that you can get the help you need to prevent or reduce problems related to diabetes, where **0** is not sure at all and **10** is very sure?
0 1 2 3 4 5 6 7 8 9 10

Goal Setting

- What areas of diabetes would you like to learn more about?
 What is diabetes? Pills for diabetes High blood sugar Low blood sugar Diet
 Exercise Stress Sick Days Pregnancy Blood testing
 Complications Insulin Pumps
- Having diabetes means you may need to make changes; if any, what changes would you like to make now?
 Being active Eating healthily Medication taking
 Monitoring Living with diabetes Using healthy coping strategies
 Problem solving for blood sugars and sick days Reducing risks of diabetes complications
 None of the above Other: _____

Please bring this questionnaire to your 1st appointment. Thank you!