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
   ☐ White/Caucasian ☐ Native Hawaiian or other Pacific Islander ☐ 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

1. 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 ☐ Numbness/pain/tingling of hands/feet

   ☐ Depression or anxiety ☐ Stroke ☐ Circulation problems

   ☐ Obesity ☐ Shortness of Breath

   ☐ Other health problems:_____
2. Do you have any allergies? ☐ No ☐ Yes: Medication/foods:_____
3. Do you smoke? ☐ No ☐ Have you ever smoked in the past?

   ☐ Yes: How long did you smoke for? _____ ☐ Yes: 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?_____
4. 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 ☐ IUD ☐ Depo-Provera shots ☐ Norplant ☐ Tubal ligation

Women only: Pregnancy

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

Family History

1. 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) 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? ☐ Yes ☐ No
   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: _____ Sweets: _____ Sugar-free deserts/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 ☐ Vegetable/Corn ☐ Olive
   ☐ 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? ☐ No ☐ Yes
   Type 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? ☐ Yes ☐ No_____
2. Do you carry a source of sugar with you? ☐Yes ☐No
   If "yes," what kind?_____
3. Have you ever had to give Glucagon? ☐ Don't know ☐ Yes ☐ No
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 sugars? ☐ 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? ☐ Yes ☐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? ☐ No ☐ Yes
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? ☐ No problems

   ☐ Recent death ☐ Separation ☐ Divorce ☐ Illness ☐ Unemployment ☐ Financial difficulties

   ☐ Housing problems ☐ 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

1. How often do you have your eyes checked by an eye doctor? _____

   Date of last exam(with drops in the eyes) : _____
2. Do you wear glasses? ☐ No ☐ Yes/For what?_____
3. Have you noticed any changes in your skin recently? ☐No ☐Yes

   If "yes," please describe: _____
4. How often do you check your feet at home? ☐ Daily ☐ Weekly ☐ Never ☐ Other _____
   Date of last foot exam by doctor: _____
5. How often do you have a dental checkup? _____ Date of last checkup: _____
6. Have you ever had a shot to prevent pneumonia? ☐ No ☐ Yes When: _____

7. Have you received a flu shot within the year? ☐ No ☐ Yes When: _____
8. Have you had your blood pressure checked? ☐ No ☐ Yes When:_____
9. Have you had a fasting glucose (blood sugar) checked? ☐ No ☐Yes When:_____
10. Have you had your cholesterol and triglycerides checked? ☐ No ☐ Yes When: _____
11. Have you had an A1c test done? ☐ No ☐ Yes When: _____
12. Do you wear a bracelet or keep something with you that identifies you as having diabetes?
    ☐ Yes ☐ No
13. 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

1. 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
2. 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
   ☐ Problem solving for blood sugars and sick days ☐ Reducing risks of diabetes complications
   ☐ Living with diabetes ☐ Using healthy coping strategies
   ☐ None of the above ☐ Other: _____

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