Diabetes Self-Management Questionnaire

General Information

1. Name: ___________________________ Age: _______ Date: ______________
2. Address: _________________________ City: ____________ Zip Code: __________
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 □ Yes: 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? _______________________

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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? ____________________________

7. 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!