

## 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?

<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> High Cholesterol/Triglycerides	<input type="checkbox"/> Kidney/Bladder problems
<input type="checkbox"/> Eye or vision problems	<input type="checkbox"/> Frequent nausea, vomiting, constipation, diarrhea	
<input type="checkbox"/> Surgery in the last 5 years	<input type="checkbox"/> Heart disease/Chest pain	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression or anxiety	<input type="checkbox"/> Circulation problems
<input type="checkbox"/> Obesity	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> 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?

<input type="checkbox"/> No method is used	<input type="checkbox"/> Postmenopausal	<input type="checkbox"/> Birth control pills	<input type="checkbox"/> Condoms
<input type="checkbox"/> Norplant	<input type="checkbox"/> Tubal ligation	<input type="checkbox"/> Depo-Provera shots	<input type="checkbox"/> 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!**