Diabetes Self-Management Questionnaire

General Information
1. Name: ___________________________ Age: ____________
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
   - Native Hawaiian or other Pacific Islander
   - White/Caucasian
   - Other: __________________________

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

Cultural Influences
1. Do you have any special dietary needs, religious and/or cultural 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:
   - Gastrointestinal problems, explain:
   - Bowel Movements per day:
   - 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
6. Do you have any other barriers to learning (for example, problems with reading, writing, and/or understanding numbers)?  
   - No  
   - Yes: Describe barrier(s):
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
   - Depression or anxiety
   - Circulation problems
   - Obesity
   - Shortness of Breath
   - Stroke
   - Numbness/pain/tingling of hands/feet
   - Other health problems: ________________________________

2. Do you have any allergies?  ❑ No  ❑ Yes: Medication/foods: ________________________________

3. Do you smoke?  ❑ No  ❑ Yes: How much? _____________________________________________________________________
   Have you ever smoked in the past?  ❑ No
   ❑ Yes: How long did you smoke for? ___________________________ How much? _____________________________________________________________________
   When did you quit? _____________________________________________________________________
   Have you ever tried to quit?  ❑ No  ❑ Yes: How long ago? _____________________________________________________________________
   Would you like information on how to quit?  ❑ No  ❑ Yes

4. Do you drink alcohol?  ❑ No  ❑ Yes  If "yes," amount and type: _____________________________________________________________________

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?  ❑ No  ❑ Yes
   If "yes," describe reason(s) and where: _____________________________________________________________________

4. Have you been to the emergency room within the last 12 months?  ❑ No  ❑ Yes
   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? □ No □ Yes If “yes,” I’ve □ lost / □ gained_______ lbs.

   Was the weight change intentional? □ No □ Yes:______________________________

3. Highest Weight/Age:_________ Lowest Weight/Age:_________ Provider/Physician Goal Weight:_________

4. Have you ever received diet counseling? □ No □ Yes If “yes,” describe:______________________________

5. Do you have a current meal plan?____________________ If so, what is it?______________________________

6. What is your biggest challenge to eating healthily?______________________________

7. How many times do you eat per day? □ Meals:____________________ □ Snacks:____________________

8. Times of meals: am:____________ noon:____________ pm:____________ snacks:____________

9. If you are a minor and/or a student, which meals do you eat at school?______________________________

10. How often do you eat/drink (answer per day or per week):

    □ Fruit:_______ □ Vegetables:_______ How much water per day?______________ □ Alcohol:______________

    □ Milk:_______ □ Fat-free □ 1 % □ 2 % □ Whole □ Soy □ Almond □ Other milks ___________

    Beverages with sugar: Juice:______________ Soft drinks:______________ Others:______________

    Sweets/desserts:_____________________ Sugar-free desserts/drinks:____________________

    **Starches eaten:** State number of servings eaten meal or per day

    □ Bread:_______ □ Cereal:_________ □ Beans:_________ □ Tortillas:_________ □ Rice:______________

    □ Pasta:_______ □ Corn/Peas:_______ □ Potatoes:_________ □ Oats:_________ □ Other:______________

    **Meats/Proteins:** State number of times eaten per week

    □ Chicken:_________ □ Red Meats:_________ □ Fish:_________ □ Turkey:____________________

    □ Pork:_______ □ Eggs:_________ □ Cheese:_________ □ Nuts/Nut butters:_________

    □ Other:____________________

    **Cooking Oil/Fat used:**

    □ Lard/Shortening:_________ □ Butter/Margarine:_________ □ Olive:______________

    □ Vegetable/Corn:_______ □ Canola:_______ □ Peanut:_________

    □ Other:____________________

11. Who does the cooking?____________________ Who usually does the grocery shopping?____________________

12. How many times during the week do you eat away from home?____________________

13. How often is your meal away from home:  Cafeteria style:_________ Fast food:_________ Buffet:_________

    Sit-down restaurant:_________ Other:____________________
14. How is your food usually prepared?  ❑ Fried  ❑ Baked  ❑ Broiled  ❑ Grilled  ❑ Steamed  ❑ Boiled
   ❑ Other forms(s)__________________________________________

15. How would you describe your portions?  ❑ Small  ❑ Average  ❑ Large

16. How would you describe your appetite?  ❑ Increased  ❑ Normal  ❑ Decreased

17. List any food allergies or intolerance:______________________________________________________

18. Any other special diet needs:____________________________________________________________

19. How do mood/stress affect your eating?____________________________________________________

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Food Insecurity

1. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn’t enough money for food?  ❑ No  ❑ Yes
   If yes, how often did this happen?  ❑ Almost every month  ❑ Some months but not every month  ❑ In 1-2 months

2. In the last 12 months, did you ever eat less than you felt you should because there wasn’t enough money for food?  ❑ No  ❑ Yes

3. In the last 12 months, were you ever hungry but didn’t eat because you couldn’t afford enough food?  ❑ No  ❑ Yes

4. Answer the following statements regarding your food situation:
   1) “The food that I bought just didn’t last, and I didn’t have money to get more.”
      ❑ Often true  ❑ Sometimes true  ❑ Never true
   2) “I couldn’t afford to eat balanced meals.”
      ❑ Often true  ❑ Sometimes true  ❑ Never true

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Being Active

1. Do you exercise regularly?  ❑ No  ❑ Yes  Types of exercise(s):______________________________________________
   How many days per week do you exercise:________  How many minutes do you exercise per day:________
   What time of day do you exercise:________
   Note: If you are a minor/student, please include exercise during PE in school.

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? (Circle one):
   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? (Circle one):
   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? (Circle one):

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? (Circle one):

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. Do you take insulin?  ❏ No (If NO proceed to question #6)  ❏ Yes

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? (Circle one):
   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? (Circle one):
   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: How often?  ❑ Rare  ❑ 1-2 times per week  ❑ Daily  ❑ Other________________________
   If "yes," how did you feel?________________________________________
   How did you treat it?______________________________________________
   Did you require assistance or hospitalization for it?  ❑ No  ❑ Yes: When/Where?________________________

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? (Circle one):
   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? (Circle one):
   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? (Circle one):
   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
   ❑ None  ❑ Other:

8. DURING THE PAST MONTH have you experienced any of the following and to what degree?
   1 – Not a Problem  2 – A Slight Problem  3 – A Moderate Problem  4 – Somewhat Serious Problem
   5 – A Serious Problem  6 – A Very Serious Problem

   1) Feeling overwhelmed by the demands of living with diabetes (Circle one):  1 2 3 4 5 6
   2) Feeling that I am often failing with my diabetes routine (Circle one):  1 2 3 4 5 6

9. Are you currently experiencing any of the following?
   ❑ No problems  ❑ Recent death  ❑ Separation  ❑ Divorce  ❑ Illness  ❑ Unemployment
   ❑ Financial difficulties  ❑ Housing problems  ❑ Loneliness  ❑ Confusion
   ❑ Depression symptoms  ❑ Thoughts of hurting yourself  ❑ Other:

10. 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?  ❑ Yes  ❑ No
   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. Do you have a Diabetes Emergency Plan?  ❑ Yes  ❑ No

14. 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? (Circle one):
   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  ❑ Emergency Preparedness

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  ❑ 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:__________________________

Women Only

1. Date of last Pap smear/pelvic exam:__________________________ Last mammogram:__________________________

2. How many pregnancies have you had?__________________________ Abortions/miscarriages:__________________________

3. How many living children do you have?__________________________ Complications of pregnancy:__________________________

4. Were you ever told you had diabetes in pregnancy?  ❑ No  ❑ Yes

5. Did you have any children that weighted over 9 pounds at birth?  ❑ No  ❑ Yes

What method of birth control do you use?
   ❑ No method is used  ❑ Postmenopausal  ❑ Birth control pills  ❑ Condoms
   ❑ Norplant/Implanon/Nexplanon  ❑ Tubal ligation  ❑ Depo-Provera shots  ❑ IUD
   ❑ Other:__________________________

Women Only: Pregnancy

1. Are you currently pregnant?  ❑ No  ❑ Yes  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?  ❑ No  ❑ Yes