Natividad
Inspiring healthy lives

Diabetes Education Center
1441 Constitution Boulevard, Salinas, CA 93906
(831) 755-6292 | www.natividad.com

Diabetes Self-Management Questionnaire

General Information

1. Name:_____ Age:_____
2. 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

1. How many family members live in your household? _____
2. Occupation:_____ Work hours:_____
3. Last grade of school completed:_____
4. Any religion preference?_____

Cultural Influences

1. Do you have any special dietary needs, religious and/or cultural observances? ❑ No ❑ Yes
   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

Diabetes Health Attitudes / Learning

1. Have you ever been instructed on diabetes care? ❑ No ❑ Yes: Where and by whom?

   _____
2. 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 ❑ Problems with the use of your feet
   ❑ Vision loss (not corrected by glasses or contacts) ❑ No problems
3. 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 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 to food or medication? ❑ No ❑ Yes: _____

3. Do you smoke cigarettes or vaping devices? ❑ No ❑ Yes: How much? _____
   Would you like information on how to quit? ❑ No ❑ Yes

4. Do you drink alcohol? ❑ No ❑ Yes: amount and type? _____

Family History

1. List any immediate family members (i.e., mother, father, grandmother, grandfather, and/or siblings) with:

   diabetes: _____ high blood pressure: _____

   heart attacks or other heart problems: _____

   stroke: _____ cancer: _____

Food Insecurity

1. In the last 12 months, did you ever eat less 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 eat less than you should because you didn't have enough money for food?
   ❑ No ❑ Yes

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

Monitoring

1. Do you test your blood for sugar? ❑ No ❑ Yes

   If "yes," what blood sugar monitor or CGM do you use? _____

   How often do you test? ❑ Once a day ❑ 2 or more times a day ❑ Once/Twice a week ❑ Rarely/Never

2. What are your usual blood sugar results? _____ What are **your** target numbers? _____

Taking Medications

1. Do you take medications for diabetes? ❑ No ❑ Yes

   If yes, which ones and what times? _____

2. Any side effects from the medications? ❑ No ❑ Yes: _____

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

4. Do you take insulin? ❑ No **(proceed to next section)** ❑ 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: How often? _____

   Where do you dispose your syringes? _____

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

Problem Solving

1. Have you ever had a low blood sugar reaction?

   ❑ No ❑ Yes: How often? ❑ Rare ❑ 1-2 times per week ❑ Daily ❑ Other _____

   How did you feel? _____

   What did you do to 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: What kind? _____

3. Have you ever been given glucagon? ❑ No ❑ Yes ❑ Don't Know

4. Have you ever had high blood sugar? ❑ No ❑ Yes ❑ Don't Know

   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: _____

Healthy Coping

1. My diabetes has caused problems in the following areas:
   - ❑ Family life/social activities ❑ Work/school ❑ Sports/exercise ❑ Sexual relations
   - ❑ Finances ❑ Contentment ❑ Travel ❑ None
   - ❑ Other:_____

2. DURING THE PAST MONTH have you experienced any of the following and to what degree?

   1) Feeling overwhelmed by the care that living with diabetes requires
      ❑ Often ❑ Sometimes ❑ Never

   2) Feeling that I am often failing with my diabetes routine
      ❑ Often ❑ Sometimes ❑ Never

Reducing Risks

1. Which of the following have you done in the past year?
   - ❑ Dilated eye exam ❑ Dental exam ❑ Foot exam
   - ❑ A1C blood test ❑ Blood pressure check ❑ Cholesterol blood test

2. Have you received the following vaccinations?
   - ❑ Pneumococcal ❑ Flu shot (within the year) ❑ COVID-19
   - ❑ Shingles (age 50 or older) ❑ RSV (age 60 or older) ❑ Hepatitis B ❑ Tdap

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. 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:_____

Healthy Eating

1. Weight: _____ What weight are you comfortable at? _____
2. Has your weight changed in the past three months? ❑ No ❑ Yes: I've ❑ lost / ❑ gained _____ lbs
3. Have you ever received diet counseling? ❑ No ❑ Yes Describe: _____
4. Do you have a current meal plan?_____ If so, what is it?_____
5. How many times do you eat per day? ❑ Meals:_____ ❑ Snacks:_____
6. Who does the cooking?_____ Who does the grocery shopping?_____
7. How many times do you eat away from home **per week/month**?_____
8. Do you drink at least 8 cups (equivalent to 64 ounces or 2 liters) of water daily? ❑ No ❑ Yes

   If no, how much water do you drink daily? _____

How often do you eat/drink the following:	Never	1-3 times per **month**	1-3 times per **week**	4-6 times per **week**	1 or more times per **day**
Fruits					
Vegetables					
Sweets/desserts					
Juice, sports drinks, energy drinks					
Soda					
Beef					
Butter, margarine, lard					

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?_____
2. List any problems with exercise: _____

Women Only

1. Have you had a Pap smear/pelvic exam in the last 3-5 years? ❑ No ❑ Yes
2. If over 40 years of age, have you had a mammogram in the last 1-2 years? ❑ No ❑ Yes
3. Were you ever told you had diabetes in pregnancy? ❑ No ❑ Yes
4. Did you have any children that weighted over 9 pounds at birth? ❑ No ❑ Yes
5. Are you currently pregnant? ❑ No ❑ Yes
6. Are you planning to become pregnant? ❑ No ❑ Yes

   If "yes," are you aware of the effects of diabetes on pregnancy? ❑ No ❑ Yes