PRE-PUMP QUESTIONNAIRE

Our goal is to provide you with the care and training that you need to best manage your diabetes on an insulin pump. To help us know how we can help you the best, please answer the following questions as completely as you can.

PLEASE PROVIDE THE FOLLOWING INFORMATION *(Circle or indicate answer with check mark where appropriate)*

General Information

Name: _____

Address: _____

_____

Age: _____ Sex: male female Height: _____ Weight: _____
Marital Status: single married widowed divorced
Occupation: _____ Work hours: _____
Living situation: ☐ live alone ☐ live with _____
When did you last participate in formal diabetes education? _____

Who is your primary care MD?	Name:
	Address:
	Phone:
Who is your diabetes MD?	Name:
	Address:
	Phone:

Diabetes Health History

What type of diabetes do you have? Type 1 Type 2 How long have you had diabetes? _____
Do you have any other health problems? Yes No If yes, please describe: _____

Have you ever been hospitalized with ketoacidosis? Yes No If yes, please write date and describe: _____

Do you ever have insulin reactions (low blood sugars)? Yes No If yes, how often? _____times / week / month
Have you ever been hospitalized due to an insulin reaction? Yes No If yes, write date and describe the cause:

JOSLIN DIABETES CENTER AFFILIATE at St. Vincent Charity Hospital
Phone: 216-363-3301 Fax: 216-363-3304

ST. VINCENT CHARITY
MEDICAL CENTER
2351 EAST 22ND STREET
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A Ministry of the Sisters of Charity Health System

PATIENT LABEL

MR.JDCPUMQUEST

Diabetes Health History, continued

How do you treat insulin reactions? _____

Do you ever need assistance to treat insulin reactions? _____

What is your most recent glycosylated hemoglobin A1C? _____ when? (mo/yr.) _____

What is your goal for your A1C? _____

When was your last dilated eye exam? _____ Ophthamologist: _____

Results? _____ Have you ever had laser treatment? Yes No

Medications

Insulin Schedule:

Time	Usual Dose	Type

Do you rotate insulin injection sites? Yes No

Have you had any problems with your injection sites? Yes No

If yes, please describe _____

_____

Other Medications:

List any other medications you take:

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

Medication: _____ Dose: _____ Time: _____

List any medication allergies: _____

_____

_____

Diabetes Monitoring

Do you check your blood glucose at home? Yes No

What type of meter do you have? _____ Do you keep a blood glucose record? Yes No

How many times do you usually check your blood glucose? _____ per day; _____ per week

Check off the times you typically check your blood glucose:

- ☐ before breakfast
- ☐ after breakfast
- ☐ before lunch
- ☐ after lunch
- ☐ before dinner
- ☐ after dinner
- ☐ before bed
- other times: _____

Do you check your urine for ketones? Yes No If yes, when? _____

PATIENT LABEL

Diabetes Monitoring, continued

Can you usually tell when your blood glucose is low? Yes No
How do you feel when your blood glucose gets too low? _____
How low is your blood glucose when you begin to "feel low"? _____
What do you do when your blood glucose is too low? _____

Can you usually tell when your blood glucose is high? Yes No
How do you feel when your blood glucose gets too high? _____
What do you do when your blood glucose is too high? _____

If you are sick, how does this affect your blood glucose? _____
How do you manage your blood glucose when you are sick? _____

Nutrition

When did you last meet with a registered dietitian? _____

Has your weight changed in the last six months? Yes No
If yes, ☐ gained _____ pounds
☐ lost _____ pounds
Can you explain why you gained or lost weight? _____

Explain any concerns you have about your weight or eating habits: _____

Do you currently follow a meal plan? Yes No
If yes, please describe _____
How often do you estimate that you are able to follow it? Never 25% 50% 75% Always

Do you count carbohydrates? Yes No Who prepares the food at home? _____

How many times each week do you eat these meals away from home?
_____ breakfast _____ lunch _____ dinner _____ snacks

Do you drink alcoholic beverages? Yes No If yes, what type? _____
How often? _____

Physical Activity

Do you do any regular exercise? Yes No
If yes,

what do you do?	How long?	How often?	What time of day?

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Physical Activity, continued

Does exercise affect your blood glucose? Yes No
If yes, please explain: _____

Do you adjust your food or insulin for exercise? Yes No
If yes, please explain: _____

If your job physically strenuous at times? Yes No
If yes, please explain: _____

Coping

Which of the following get in the way of your diabetes care?

☐ stress ☐ money ☐ health problems ☐ friends
☐ work ☐ emotions ☐ lack of time ☐ family
☐ lack of knowledge ☐ other: please specify _____

Has your diabetes caused a problem in the following areas? Please explain.

Work or school: _____
Sports or exercise: _____
Travel: _____
Dating or sexual relations: _____
General lifestyle: _____

Pump Therapy

How were you referred to our program?
☐ Self-referred Doctor: _____ Other: _____

Have you ever been on intensive insulin therapy and or pump therapy? Yes No

What goals will insulin pump therapy help you attain?

_____

How do you think a pump will improve what you are doing now to manage your diabetes?

_____

How long do you expect it will take for you to achieve desired “control” once you start pump therapy?

_____

Do you think wearing a pump will be a problem in your personal relations?

_____

_____
Pump-Trainer Signature Date

PATIENT LABEL