DIABETES SELF-MANAGEMENT QUESTIONNAIRE

Name: _____ **Medical Record #:** _____ **Today's Date:** _____

In order to plan a diabetes education program that best meets your needs, please answer these questions about your diabetes and how you care for yourself. Answer the questions based on what has happened over the past 3 months unless stated otherwise. There are no right or wrong answers.

Tell us what you think:	**Not at all**	**Somewhat**	**Very**
• How satisfied are you with how you are managing your diabetes?	**1**	**2**	**3**
• How important is making changes to improve your diabetes care?	**1**	**2**	**3**

What is your **main goal** for diabetes education? _____

In what year were you **born**? 19_____ **Sex:** ☐ M ☐ F

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Pre-diabetes

☐ Don't know In what year were you first diagnosed? _____

Have you had ***instruction*** from a health professional or attended classes on diabetes? ☐ Yes ☐ No

If yes, when? ☐ Within past year ☐ 2 - 4 years ago ☐ 5 or more years ago

Check the 2 - 3 topics that you are most interested to learn about or discuss at the time of your visit:

☐ Improving eating habits
☐ Increasing physical activity
☐ Preventing complications
☐ Reducing high blood sugars
☐ Monitoring blood sugar
☐ How diabetes medicine works
☐ Feeling less blue or depressed
☐ Other: _____
☐ Preventing low blood sugars
☐ Improving sexual function
☐ Stopping smoking

Who helps you with your diabetes care (family or friends)? _____

Do you have any ***religious, cultural or personal health beliefs*** that you would like considered as we help you develop your diabetes care plan? ☐ Yes ☐ No If yes, describe _____

Joslin is committed to protecting the privacy of our patients' personal health information and ensuring the integrity of such information. To achieve this goal, we have used industry-recognized security systems and internal procedures. A code of conduct exists for those staff members that are permitted to access patients' personal medical information and this code forbids staff members from using, copying, reading, or distributing patients' medical information except as is necessary to provide healthcare and to carry out healthcare operations.

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MR.JDCSELFQUEST

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PATIENT LABEL

SVPOD-130 (1/05)

Medicines

Do you take medicine for your diabetes? ☐ Yes ☐ No ***If no,*** skip to the next section. ***If yes,*** what kind?

☐ Diabetes pills ☐ Insulin injections ☐ Insulin pump ☐ Other: _____

List the medications you take	How much you take (dose)?

Check if any of the following are ever a problem for you: ☐ forgetting to take it ☐ side effects

☐ taking wrong amount ☐ taking it at wrong times ☐ soreness, lumps or bruises at injection site

Do you take aspirin daily? ☐ Yes ☐ No

Low Blood Sugar

How often do your blood sugars run *low* or below target (goal) range? ☐ don't know

☐ daily ☐ few times a week ☐ once a week ☐ few times a month ☐ once in a while ☐ never

Check any of the following that you do if your blood sugar is too low:

☐ Adjust dose of medicine
☐ Adjust carbohydrate/food intake
☐ Check glucose levels more often
☐ Skip or omit medicine
☐ Skip or omit meals
☐ Other: _____
☐ Adjust physical activity
☐ Call my healthcare provider

High Blood Sugar

How often do your blood sugars run *high* or above target (goal) range? ☐ don't know

☐ daily ☐ few times a week ☐ once a week ☐ few times a month ☐ once in a while ☐ never

Check any of the following that you do if your blood sugar is too low:

☐ Adjust dose of medicine
☐ Adjust carbohydrate intake
☐ Check glucose levels more often
☐ Skip or omit meals
☐ Adjust physical activity
☐ Call my healthcare provider
☐ Drink more water
☐ Check for ketones
☐ Other: _____

PATIENT LABEL

Monitoring Blood Sugar

Do you check your blood sugar using a meter? ☐ Yes ☐ No ***If yes:***

How many times a day do you check? ☐ 1 - 2 times/day ☐ 3 or more ☐ few times/wk ☐ rarely

What are your usual fasting blood sugar results (before eating your first meal)?

☐ greater than 300 ☐ 200 - 300 ☐ 150 - 200 ☐ 100 - 150 ☐ 70 - 100

What is your A1C target? _____ Check here if you don't know it: ☐

Physical Activity

About how many total ***minutes*** per week are you physical active? _____minutes

Check any of the following that ever get in the way or cause problems with your being physically active:

☐ Low blood sugar ☐ High blood sugar ☐ Ketones ☐ Other health concerns

☐ Not sure what I can do

Meal Plan

Have you received instructions for a meal plan for diabetes? ☐ Yes ☐ No If yes, when? _____

How many calories? _____ ☐ I don't remember

How much carbohydrate? _____ (grams or servings/day) ☐ I don't remember

How often do you follow a meal plan? ☐ Never-rarely ☐ Sometimes ☐ Few times week ☐ Daily

Check the boxes that best describe the usual way you eat (Check all that apply):

☐ Count carbohydrates ☐ Count calories ☐ Use exchange lists ☐ Avoid sugars

☐ Reduced fats ☐ Weigh and measure food ☐ No special meal plan

Would you like to lose some weight? ☐ No ☐ Yes How much? _____

How much alcohol do you drink? ☐ None ☐ A few drinks a week ☐ 1 - 2 drinks / day ☐ More

Other Medical Concerns

Check any problems you may be experiencing:

☐ High blood pressure (hypertension)
☐ High blood cholesterol
☐ Sexual function problems
☐ Numbness in feet or hands (neuropathy)
☐ Heart problems
☐ Recent weight loss
☐ Vision problems (blurred vision, cataracts, retinopathy)
☐ Foot problems
☐ Kidney problems (nephropathy)
☐ Other: _____

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Other

Do you smoke? ☐ Yes ☐ No If yes, how many packs per day? _____ For how long? _____

If no, were you ever a smoker? ☐ Yes ☐ No If yes, did you quit in the past year? ☐ Yes ☐ No

When did you last see an eye doctor for a dilated eye exam? _____

When did you last have your feet checked by a doctor? _____

How often do you inspect your feet? ☐ Daily ☐ Few times/wk ☐ Once/wk ☐ Sometimes ☐ Rarely

For women of child bearing age (over age 12): Do you use birth control? ☐ Yes ☐ No ☐ Not applicable

Do you plan to become pregnant in next year? ☐ Yes ☐ No

Which of the following gets in the way of managing your diabetes (check as many as apply)

☐ Nothing	☐ Money	☐ Health Problems	☐ Stress
☐ Work	☐ Friends	☐ Lack of time	☐ Feeling depressed
☐ Emotions	☐ Family	☐ Lack of knowledge	

Other (describe): _____

The End.
Thank you for completing this form.

To be completed by the diabetes educator:

Skill check:

Monitoring: _____

Insulin injection: _____

Knowledge/behavior review:

Education Plan:

☐ Comprehensive DSME program _____

☐ Individual consult: _____

DSME goals: _____

_____

Diabetes Educator Signature / Date

PATIENT LABEL