www.denbahamas.com • 702-9310 • acates@familymedicinecenter.org

Diabetes Self Care Assessment Form

The information you provide in this assessment will allow us to focus on your specific needs and provide the highest level of care possible.

*Please allow 30-60 minutes to complete the form in its entirety. There are 10 sections.

Section 1 - Contact Information

Today's Date: Month Day Year

Patient's Full Name:

Who is filling out this form? Patient Caregiver

Gender: Female Male

What do you like to be called?

Date of Birth: Month Day Year

Significant Other:

Relationship:

Children/ages:

Type of Health Insurance (incl. company name):

Address: P.O. Box:

Island:

Home Phone:

Cell Phone:

Work Phone:

What is your preferred contact number: ○ home ○ cell ○ work

Do you prefer to visit via skype/video? OR do you prefer phone calls? ○ Skype ○ Phone

If you prefer using Skype, what is your Skype Name?

E-mail:

How did you hear about us?

Do you want us to send reports to your physician? ○ yes ○ no

Section 2 - Your Goals

What are some of your specific needs and expectations?

Section 3 - Health Background

Type of Diabetes:

- ◯ Type 1
- ◯ Type 2
- ◯ Other

How old were you when your diabetes was diagnosed?

Most recent diabetes education:

Do you know what causes your form of diabetes? Please explain...

Recent lab results (& date)

	Lab Results	Date
HbA1c:		
Total Cholesterol:		
HDL Cholesterol:		
LDL Cholesterol:		
Triglycerides:		
Microalbumin:		
TSH:		

Do you have any of the following diabetic complications?

	Yes	No	I don't know
Retinopathy (blood vessel damage to the retina of the eye)	◯	◯	◯
Nephropathy (kidney disease)	◯	◯	◯
Coronary Artery Disease (blocked blood vessels leading to the heart)	◯	◯	◯
Peripheral Vascular Disease (impaired circulation in the legs or feet)	◯	◯	◯
Foot Infections/Ulcers	◯	◯	◯
Peripheral Neuropathy (tingling, pain, or numbness in the legs or feet)	◯	◯	◯
Autonomic Neuropathy (nerve disease affecting basic bodily functions)	◯	◯	◯
Periodontal Disease (gum disease)	◯	◯	◯

If Yes, please explain your diabetic complications:

Have you experienced any of the following during the past several weeks?

- ☐ Dizziness when Standing
- ☐ Leg Pain when Walking/Standing
- ☐ Frequent Diarrhea
- ☐ Ingrown Toenails
- ☐ Vomiting/Abdominal Pain
- ☐ Redness/Swelling of the Feet
- ☐ Chest Pain/Shortness of Breath
- ☐ Sexual Dysfunction
- ☐ Vaginal Yeast Infections
- ☐ Blurred/Obstructed Vision in one eye
- ☐ Urinary Tract Infections
- ☐ Bleeding Gums w/Brushing
- ☐ Numbness/Tingling
- ☐ Discomfort with Chewing
- ☐ Pain/Burning in Legs or Feet
- ☐ Loose Teeth
- ☐ Sleep problems: too little sleep
- ☐ Sleep problems: too much sleep
- ☐ Night Time Urination

Please list any health problems (besides diabetes)

What medications do you take (besides your diabetes medications)?

Do you have a FAMILY history of: ☐ Diabetes ☐ Heart Attack ☐ Stroke ☐ Obesity

Section 4 - Diabetes Medications

Oral Medications

Do you take any pills for your diabetes? ○ yes ○ no

Do you understand how your pills work to control diabetes? ○ yes ○ no

If you don't currently use pills for your diabetes, have you used any in the past?
○ yes ○ no

Injectables

Do you take any of the following Injectables:

	Dose	Frequency
Byetta (exenatide)		
Symlin (pramlintide)		
Victoza (liraglutide)		
Bydureon		

How difficult is it to control your appetite?

	1	2	3	4	5	6	7	8	9	10	
Very Easy	○	○	○	○	○	○	○	○	○	○	Very Hard

Do you take insulin? ○ yes ○ no

Section 5 - Blood Glucose Monitoring

Do you test your blood sugar with a home blood glucose meter? ◯ yes ◯ no

Do you download your meter? ◯ yes ◯ no

How often do you check your blood sugar?

once a day

At what times do you check your blood sugar? (check all that apply)

☐ upon waking ☐ before meals ☐ before snacks

☐ 2 hours after meals ☐ at bedtime ☐ 1 hour after meals

☐ before driving ☐ before exercise ☐ other

Do you use a lancing pen? ◯ yes ◯ no

Do you keep written records of your blood sugars? ◯ yes ◯ no

What else do you record? (check all that apply)

☐ insulin/meds ☐ carbs/food ☐ exercise/activity

☐ stress ☐ monthly cycle ☐ other

** if possible, please provide us with the last 2-4 weeks of your written records*

What do you consider an acceptable range for your premeal blood sugars?

In the chart below, EACH column should add up to 100%

Approximately what percentage of your blood sugars are above, within and below your target range? (note: each column should add to 100%)

	Before breakfast	Before lunch	Before dinner	Before bed
% above target				
% within target				
% below target				
TOTAL	0	0	0	0

Are you currently using a Continuous Glucose Monitor? ◯ yes ◯ no

Section 6 - Hypoglycemia

How often do you experience hypoglycemia (low blood sugar)?

never

At what time/s of day does hypoglycemia usually occur?

What symptoms do you notice when your blood sugar is low?

How low does your blood sugar need to be before you notice any symptoms?

Do you carry a sugar source with you? ○ yes ○ no

Describe what you usually eat (and how much) when your blood sugar is low:

Do you have a glucagon emergency kit?
○ yes ○ no ○ I don't know what that is!

Has glucagon ever been administered to you? ○ yes ○ no

How severe was your worst hypoglycemic episode? mild, no help needed

Do you drive? ○ yes ○ no

What form(s) of medical identification do you wear/carry?

- ☐ Bracelet Necklace
- ☐ Pin
- ☐ Anklet
- ☐ Tattoo
- ☐ Wallet Card
- ☐ Other

How often do you wear it? never without it

Section 7 - Diet/Nutrition

What is your current weight?

What is your height?

Describe any weight change over the past year:

What is your target weight?

When were you last at that weight?

Have you ever received instruction on weight loss or weight gain programs?

◯ yes ◯ no

In terms of your diabetes, what do you currently do to manage your diet?
(check all that apply)

- ☐ Nothing special
- ☐ Avoid sugar
- ☐ Limit fat
- ☐ Restrict calories
- ☐ Eat the same things each day
- ☐ Follow an exchange diet
- ☐ Count carb “units” or “exchanges”
- ☐ Count grams of carbohydrate
- ☐ Other, please explain

Do you use Apps on a smart phone or tablet to help you track your diet?

◯ yes ◯ no

If counting carbs, do you make any adjustments for fiber? ○ yes ○ no

How about sugar alcohols? ○ yes ○ no

Glycemic index values? ○ yes ○ no

Do you take daily supplements? ○ yes ○ no

Please check all that apply:

☐ Multi-vitamin	☐ Aspirin	☐ Niacin	☐ Folic acid
☐ B Complex	☐ Vitamin C	☐ Chromium	☐ Magnesium
☐ Ginseng	☐ Psyllium	☐ Vitamin E	☐ Calcium
☐ Herbal	☐ Prenatal	☐ Other	

Do you ever omit/reduce your insulin/medication to lose weight? ○ yes ○ no

Have you ever, binged/purged? ○ yes ○ no

Have you ever suffered from an eating disorder? ○ yes ○ no

How often do you skip meals? rarely

Is there a reason you skip meals?

How often do you eat at restaurants (or do take-out)?

once a week or less

What restaurants do you usually visit?

What types of ethnic foods (if any) do you enjoy?

Which meals/snacks do you eat on a typical day? Note all that apply.

	Approximate time	Typical foods & drinks	Estimate of carbohydrates in this meal
breakfast			
morning snack			
lunch			
afternoon snack			
dinner			
evening snack			

Does your meal/snack schedule differ on weekends/off days? ○ yes ○ no

Section 8 - Physical Activity

How would you describe your current overall activity level?

moderate (some exercise, and at least an hour home/work activity)

How do you feel about exercise?

Have any of your health care providers recommended exercise? ○ yes ○ no

Have any told you to limit your exercise or not exercise? ○ yes ○ no

Have you ever had an exercise stress test? ○ yes ○ no

Does anything prevent you from exercising? If so, what?

What kind of exercise equipment do you have at home?

Do you have access to any exercise/fitness facilities? ○ yes ○ no

Are you using any Apps on a smart phone or tablet to help track your exercise? Please list.

Is there any form of exercise that you are interested in trying?

Describe what you do to keep physically active, if anything. Make note of seasonal activities (even if not in current season).

	Type of Activity	How many minutes?	Pace/ Intensity	On what days?	What time of day
1					
2					
3					
4					

Do you ever have trouble managing your blood sugar levels when exercising?

○ yes ○ no

Do you routinely make adjustments to your diabetes treatment plan to manage your blood sugars during exercise?

○ yes ○ no

Section 9 - Health Maintenance

Do you have a plan to follow for managing your diabetes in the event of illness?

yes no

What adjustments do you make in your diabetes regimen for illness, if any?

Do you test your urine or blood for ketones? yes no

How often do you… (check the box that applies)

	Never	Daily	Weekly	Monthly	Every 2-3 months	Every 6 months	Yearly	Every few years	Not sure
See your diabetes doctor?									
Have a dilated eye exam?									
Have your teeth cleaned professionally?									
Brush your teeth?									
Use Dental Floss?									
Visit a Podiatrist?									
Inspect your feet?									
Have a Hemoglobin A1C checked?									
Have your kidney function checked (microalbumin)?									
Have your cholesterol levels checked?									
Have your thyroid levels checked?									

Have you ever been checked for sprue/celiac (gluten intolerance)? yes no

Have you ever been checked for osteoporosis? yes no

What were the results?

Section 10 - Social Life

Do you smoke at all? ○ yes ○ no ○ previously

Do you drink alcoholic beverages? ○ yes ○ no

Do you use any illegal drugs? ○ yes ○ no

Please rate the amount of stress in your life

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

Very little/Manageable Intense, all the time

Do you experience bouts of depression? ○ yes ○ no

Are you sexually active? ○ yes ○ no

Have you ever had a sexually transmitted disease? ○ yes ○ no

Do your blood sugars change during your menstrual cycle? ○ yes ○ no ○ n/a

Are you planning a pregnancy? ○ yes ○ no

What is the highest level of education you have completed?

Please describe your current occupation:

What are your work/school hours?

What are your personal interests/hobbies?

How much overnight travel do you do?

yearly

What diabetes magazines do you receive?

What diabetes web sites do you visit? Please list the web addresses (url)

Are you an active volunteer with any diabetes organizations? ○ yes ○ no

Is there anything else that you want us to know?

Thank You!

We realize that this was a lengthy survey, but it will help us to do a much better job at helping you!

If you have blood sugars or other records to send, e-mail to:
acates@familymedicincecenter.org