



Label

DIABETES SELF ASSESSMENT

PATIENT INFORMATION			
Name:			
Are You Currently Working? Yes <input type="checkbox"/> No <input type="checkbox"/>		Last Grade of School Completed:	
Financial Concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Race: <input type="checkbox"/> American Indian/Alaska Nation <input type="checkbox"/> Asian/Pacific Islander/Oriental <input type="checkbox"/> Black/African American <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Other:			
Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Other:			
How many people in your household?		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
How are they related to you?			
DIABETES INFORMATION			
Have you had previous instruction on how to take care of your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, when?			
Where?			
Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please describe:			
From whom do you get support for your diabetes?			
<input type="checkbox"/> Family <input type="checkbox"/> Friends <input type="checkbox"/> Co-workers <input type="checkbox"/> Health care providers <input type="checkbox"/> Support group <input type="checkbox"/> No one			
Will someone attend class with you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name:			
LEARNING STYLE			
How do you learn best? <input type="checkbox"/> Listening <input type="checkbox"/> Reading <input type="checkbox"/> Observing <input type="checkbox"/> Doing <input type="checkbox"/> Computer (digital)/Smartphone			
Do you have any problems with: <input type="checkbox"/> Hearing <input type="checkbox"/> Seeing <input type="checkbox"/> Reading <input type="checkbox"/> Speaking			
<input type="checkbox"/> Yes, please describe: <input type="checkbox"/> No, I have no problems			
Can you read/write written instructions without difficulty? <input type="checkbox"/> Yes <input type="checkbox"/> No			
MEDICAL HISTORY			
What type of diabetes do you have? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Gestational <input type="checkbox"/> Don't know			
How long have you had diabetes? <input type="checkbox"/> New/Just Found Out Years			
Do you have any of the following?			
<input type="checkbox"/> Eye problems	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Asthma/Bronchitis/COPD
<input type="checkbox"/> Kidney problems	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Physical limitations	<input type="checkbox"/> Acid reflex/GERD
<input type="checkbox"/> Dental problems	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Numbness/tingling/loss of feeling in hands and feet
<input type="checkbox"/> Stroke	<input type="checkbox"/> Family History of Diabetes	<input type="checkbox"/> Sexual problems	
<input type="checkbox"/> Poor Circulation	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Thyroid disorders	
MEDICAL HISTORY			
In the past 12 months, have you been a patient in an emergency room or hospital because of your diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you use tobacco? <input type="checkbox"/> None <input type="checkbox"/> Cigarette <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing <input type="checkbox"/> Quit When?			
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what type of alcohol?		How many drinks per day/week/month?	
EXERCISE			
Do you exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe Activity: <input type="checkbox"/> Easy <input type="checkbox"/> Moderate <input type="checkbox"/> Strenuous			
What type of exercise? <input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Active job <input type="checkbox"/> Strength training (weights, push-ups, sit-ups) <input type="checkbox"/> Other _____			
How often do you exercise?		How long?	

DIABETES MEDICATIONS
 (If preferred, you may attach a list of current medications to this form. Include over the counter, nutritional supplements and herbs.)

DIABETES MEDICATION NAME	DOSE (mg, mcg, etc.)	HOW OFTEN (daily, twice daily, etc.)

Do you have allergies to any medications? Yes No Don't know
 If yes, list: _____
 If you take shots, which parts of your body do you use to give your shot?
 Arm Thigh Abdomen Buttocks Other _____

BLOOD GLUCOSE MONITORING

Do you check your blood sugar? Yes No If yes, type of meter: _____
 If yes, how often? Once a day 2 or more times a day Once a week Occasionally Other _____
 What time of day do you test? Before breakfast 2 hours after meals Bedtime
 Other _____
 Can you tell when your blood sugar is too high? Yes No
 If yes, what do you feel when your blood sugar is too high? _____
 Can you tell when your blood sugar is too low? Yes No
 If yes, how often and what do you feel when your blood sugar is to low? _____
 Do you carry anything with you to treat low blood sugar? Yes No If yes, what do you carry? _____

FEELINGS ABOUT HAVING DIABETES

Please state whether you agree, are neutral or disagree with the following statements:

Statement	Yes	No	Not Sure
If I take care of myself I can help prevent diabetes complications.			
Living with diabetes is stressful to me.			
My level of stress is high.			
I have concerns about my finances.			
I struggle with making changes.			
I struggle with paying for my diabetes medications.			

What are your feelings about having diabetes?
 Frustrated Angry Guilty Depressed Okay – accepting Other: _____

What would you like to learn in these diabetes sessions? Check all that apply.

<input type="checkbox"/> What to eat	<input type="checkbox"/> How to check my blood sugar
<input type="checkbox"/> Medications/Insulin – How do they work	<input type="checkbox"/> What tests and lab work do I need to stay healthy/prevent problems
<input type="checkbox"/> More about diabetes – What is it	<input type="checkbox"/> How to exercise
<input type="checkbox"/> How to lose weight	<input type="checkbox"/> How to care for my feet
<input type="checkbox"/> How to handle stress	

NUTRITION

Who is responsible for meal planning, grocery shopping, cooking, etc. in your household?
 Myself Spouse Shared Other _____
 How many times per day do you eat? One Two Three Four or more
 Please mark any dietary restrictions: None Salt Fat Fluid Sugar Other _____
 Has your weight changed over the past year? Yes No If yes, please describe how: _____
 How many meals per week do you eat away from home? None 1-2 3-4 5 or more
 Do you have any food allergies? Yes No If yes, list: _____

Women Only

Number of pregnancies: _____ Number of Live births: _____
 If yes, did you have gestational diabetes or did you have baby weighing over 9 pounds? Yes No
 Do you have any children? Yes - Ages _____ No



Burgess Diabetes Center Diabetes Knowledge Assessment

NAME: _____

DATE: _____

Please circle your answer.

It's ok if you do not know the answer to a question. We will talk about any questions you have when we meet.

1. Type 2 diabetes is a condition that happens when:
 - A. The body does not make enough insulin.
 - B. The muscle cells in your body do not use insulin well or become "resistant".
 - C. The liver produces more sugar than your body needs.
 - D. All of the above.
 - E. I don't know.

2. A Healthy Diet with Diabetes includes:
 - A. Eating carbohydrates
 - B. Lots of vegetables
 - C. Protein foods – like meat or beans
 - D. All of the above
 - E. I don't know

3. 15 grams of carbohydrate equals one carbohydrate choice: If you eat a bagel with 30 grams of carbohydrates in it how many carbohydrate choices is this?
 - A. 1
 - B. 2
 - C. 4
 - D. I don't know.

4. Physical Activity helps:
 - A. Lower my blood sugar /A1C
 - B. Lower my blood pressure
 - C. Improve my cholesterol
 - D. All of the above
 - E. I don't know

5. Keeping my blood sugar, blood pressure, and cholesterol at a healthy level lowers my risk for heart attack and stroke.
- A. True
 - B. False
 - C. I don't know
6. Checking my blood sugar daily is a way to see if my diabetes medication, food, and activity are working to manage my blood sugar.
- A. True
 - B. False
 - C. I don't know.
7. Ways to help handle the stress of managing diabetes includes:
- A. Being active
 - B. Being involved with church or a time to reflect
 - C. Having a hobby
 - D. Attending a support group
 - E. All of the above
 - F. I don't know
8. Sometimes unexpected things can affect your blood sugar. When this happens problem solving with your diabetes educator can help.
- A. True
 - B. False
 - C. I don't know
9. A micro albumin test measures protein in your urine.
- A. True
 - B. False
 - C. I don't know
10. Do you know your micro albumin test result?
- A. Yes
 - B. No
 - C. I don't know



DIABETES SELF MANAGEMENT EDUCATION PLAN OF CARE

Diabetes education is recommended at four different times in your life:

- At diagnosis
- Annually and/or not meeting treatment targets
- When complicating factors develop
- When transitions in life or care occur

This plan of care includes persons with Type 1, Type 2, Gestational diabetes and diabetes in pregnancy.

<p>_____ Individual _____ Group Diagnosis: _____</p> <p>_____ In Person</p> <p>_____ Telehealth: ___ Audio only ___ Audio-Video Combination</p>
<p>Up to 10 hours of education initially and up to 2 hours annually</p> <p>GOAL:</p> <p>Provide education and support for persons with diabetes on:</p> <ul style="list-style-type: none"> <input type="checkbox"/> What diabetes is and treatment options <input type="checkbox"/> Healthy Eating <input type="checkbox"/> Healthy Coping <input type="checkbox"/> Being Active <input type="checkbox"/> Taking Medication <input type="checkbox"/> Monitoring <input type="checkbox"/> Reduce Risk (treating acute and chronic complications) <input type="checkbox"/> Problem Solving and behavior change strategies

Number of visits anticipated: _____

How often do you plan to come for visits: _____

This care plan was reviewed with the patient, who indicated this plan is acceptable and he/she would participate.

Patient Signature

Date

Staff Signature

Date



Burgess Diabetes Center Phone and other Message consent

Name: _____		Birthdate: _____	
Address: _____		City: _____	State: _____
Zip Code: _____			
Phone number:			
Home: _____			
Cell: _____			
Work: _____			
Consent For Burgess Diabetes Center to leave a message: Please check all that apply.			
<input type="checkbox"/> I give my consent for Burgess Diabetes Center to leave a message on the answering machine of the phone number listed above.			
<input type="checkbox"/> I give my consent for the following person(s) to receive messages for me:			
Name: _____ Relationship to you: _____			
Phone number: _____			
Name: _____ Relationship to you: _____			
Phone number: _____			
<input type="checkbox"/> I give consent to leave a message by secure email at the following email address:			

<input type="checkbox"/> I give consent for an unsecure text message to the following number:			

Patient Signature: _____		Date: _____	

Witness: _____			
Date: _____			