BURGESS Health Center

Label

DIABETES SELF ASSESSMENT

PATIENT INFORMATION

Name:

Are You Currently Working? Yes ☐ No ☐ | **Last Grade of School Completed:**
Financial Concerns? Yes ☐ No ☐

Race: ☐ American Indian/Alaska Nation ☐ Asian/Pacific Islander/Oriental ☐ Black/African American ☐ White/Caucasian ☐ Hispanic/Latino ☐ Other:

Language Preference: ☐ English ☐ Other:

How many people in your household? ☐ Married ☐ Single ☐ Divorced ☐ Widowed

How are they related to you?

DIABETES INFORMATION

Have you had previous instruction on how to take care of your diabetes? ☐ Yes ☐ No

If yes, when?

Where?

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ☐ Yes ☐ No

If yes, please describe:

From whom do you get support for your diabetes?
☐ Family ☐ Friends ☐ Co-workers ☐ Health care providers ☐ Support group ☐ No one

Will someone attend class with you? ☐ Yes ☐ No If yes, name:

LEARNING STYLE

How do you learn best? ☐ Listening ☐ Reading ☐ Observing ☐ Doing ☐ Computer (digital)/Smartphone

Do you have any problems with: ☐ Hearing ☐ Seeing ☐ Reading ☐ Speaking

☐ Yes, please describe: ☐ No, I have no problems

Can you read/write written instructions without difficulty? ☐ Yes ☐ No

MEDICAL HISTORY

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Pre-diabetes ☐ Gestational ☐ Don't know

How long have you had diabetes? ☐ New/Just Found Out Years

Do you have any of the following?

☐	Eye problems	☐	Heart problems	☐	Chronic pain	☐	Asthma/Bronchitis/COPD
☐	Kidney problems	☐	High blood pressure	☐	Physical limitations	☐	Acid reflex/GERD
☐	Dental problems	☐	High cholesterol	☐	Depression/Anxiety	☐	Numbness/tingling/loss of feeling in hands and feet
☐	Stroke	☐	Family History of Diabetes	☐	Sexual problems		
☐	Poor Circulation	☐	Sleep Apnea	☐	Thyroid disorders		

MEDICAL HISTORY

In the past 12 months, have you been a patient in an emergency room or hospital because of your diabetes?
☐ Yes ☐ No

Do you use tobacco? ☐ None ☐ Cigarette ☐ Pipe ☐ Chewing ☐Quit When?

Do you drink alcohol? ☐ Yes ☐ No

If yes, what type of alcohol? How many drinks per day/week/month?

EXERCISE

Do you exercise? ☐ Yes ☐ No Describe Activity: ☐ Easy ☐ Moderate ☐ Strenuous

What type of exercise? ☐ Walking ☐ Running ☐ Active job ☐ Strength training (weights, push-ups, sit-ups)
☐ 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:

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

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.

☐	What to eat	☐	How to check my blood sugar
☐	Medications/Insulin – How do they work	☐	What tests and lab work do I need to stay healthy/prevent problems
☐	More about diabetes – What is it	☐	How to exercise
☐	How to lose weight	☐	How to care for my feet
☐	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

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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. How often should I see the eye doctor to see if diabetes is affecting my eyes?
   A. Every 3 months
   B. Yearly
   C. Every 2 years
   D. I don't know

10. Do you know the date of your last eye exam?
   A. Yes: Date completed:_____
   B. No

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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.

_____Individual _____ Group Diagnosis: _____ **_____ In Person** **_____ Telehealth: ___Audio only ____Audio-Video Combination**
Up to 10 hours of education initially and up to 2 hours annually **GOAL:** Provide education and support for persons with diabetes on: ☐ What diabetes is and treatment options ☐ Healthy Eating ☐ Healthy Coping ☐ Being Active ☐ Taking Medication ☐ Monitoring ☐ Reduce Risk (treating acute and chronic complications) ☐ Problem Solving and behavior change strategies

Number of visits anticpated: _____

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**

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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.

- ☐ I give my consent for Burgess Diabetes Center to leave a message on the answering machine of the phone number listed above.
- ☐ 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: _____
- ☐ I give consent to leave a message by secure email at the following email address:
  _____
- ☐ I give consent for an unsecure text message to the following number:

Patient Signature: _____ Date: _____

Witness: _____
Date:_____