Diabetes Assessment

BURGESS Diabetes Center

ABOUT YOU:

Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** _____

Race:

☐ American Indian or Alaska Native ☐ Asian or Asian American ☐ Black or African American

☐ Native Hawaiian or Pacific Islander ☐ White or Caucasian ☐ Other: _____

Ethnicity:

☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Other: _____

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?

☐ YES ☐ NO If YES, please describe: _____

What is your primary language? ☐ English ☐ Spanish ☐ Other: _____

Who do you live with? _____

How confident are you in filling out medical forms by yourself? ☐ Extremely ☐ Somewhat ☐ Not at All

REDUCING RISK

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____

When were you diagnosed with diabetes?

Have you had diabetes self-management education (DSMES) before? ☐ YES ☐ NO ☐ UNSURE

How often do you have high blood sugar?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

ADCES

How often do you have low blood sugar?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

Do you Smoke? ☐ YES ☐ NO Do you drink alcohol? ☐ YES ☐ NO

In the past 12 months have you been to the emergency room because of diabetes? ☐ YES ☐ NO

In the past 12 months have you been admitted to the hospital because of diabetes? ☐ YES ☐ NO

Health History:

Other health conditions: _____

Do physical limitations interfere with your ability to manage your diabetes, get physical activity, or enjoy things that you like to do? ☐ YES ☐ NO

If YES, ☐ Hearing ☐ Vision ☐ Dexterity or use of hands ☐ Feet ☐ Pain ☐ Other: _____

Which of the following have you had or done in the past year?

☐ Dilated eye exam ☐ Dental exam ☐ Had Feet Checked

☐ A1C ☐ Cholesterol ☐ Blood pressure check

☐ Stopped smoking

HEALTHY COPING

Who supports you in coping with the daily demands of managing diabetes?

☐ Family ☐ Friends/Coworkers ☐ Support Group ☐ Diabetes Care & Education Specialist

☐ Health Care Professional ☐ Other: _____

Respond to the following by answering often true, sometimes true, or never true.

Diabetes gets in the way of the rest of my life:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling overwhelmed by taking care of my diabetes:

☐ Often True ☐ Sometimes True ☐ Never True

Feeling that I am often failing with my diabetes care:

☐ Often True ☐ Sometimes True ☐ Never True

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BEING ACTIVE

On how many of the last SEVEN DAYS did you participate in at least 30 minutes of physical activity? (Total minutes of continuous activity, including walking). _____

How often do you participate in a specific exercise session (such as swimming, walking, biking) other than what you do around the house or as part of your work?

☐ Every Day ☐ A few times per week ☐ A few times per month ☐ Never

HEALTHY EATING

Do you follow a specific eating plan? ☐ YES ☐ NO

If yes, on how many of the last SEVEN DAYS did you follow your eating plan? _____

On how many of the last SEVEN DAYS did you eat five or more servings of fruits and vegetables?_____

On how many of the last SEVEN DAYS did you eat red meat or full-fat dairy foods?_____

TAKING MEDICATION

Do you take diabetes medication? ☐ YES ☐ NO

If yes, check all that apply: ☐ pills ☐ injections ☐ insulin ☐ supplements

On how many of the last SEVEN DAYS, did you take your medication and/or injections? _____

On how many of the last 7 days did you miss taking one or more of your medications or injections? _____

MONITORING

Do you check your blood sugar with a glucose meter or continuous glucose monitor (CGM)?

☐ YES ☐ NO If YES, how often do you usually check your blood sugar? _____

Have you kept a food or activity log before? ☐ YES ☐ NO

PROBLEM SOLVING:

Please rate your agreement with the following statements:

I know what to do when my blood sugar goes higher or lower than it should be

☐ YES ☐ NO ☐ UNSURE

I know when changes in my diabetes mean I should visit the doctor

☐ YES ☐ NO ☐ UNSURE

ADCES

I know I can manage my diabetes so that it does not interfere with the things I want to do.

☐ YES ☐ NO ☐ UNSURE

SOCIAL DETERMINANTS OF HEALTH:

Respond to the following by answering often true, sometimes true, or never true.

Within the past 12 months, I worried whether our food would run out before we had money to buy more.

☐ Often True ☐ Sometimes True ☐ Never True

Within the past 12 months, the food we bought just did not last and we didn't have money to get more.

☐ Often True ☐ Sometimes True ☐ Never True

How often does this describe you?

I don't have enough money to pay my bills:

☐ Often True ☐ Sometimes True ☐ Never True

I put off or neglect to go to the doctor because of distance or lack of transportation.

☐ Often True ☐ Sometimes True ☐ Never True

I am worried or concerned that I may not have stable housing soon

☐ Often True ☐ Sometimes True ☐ Never True

I have a job. ☐ YES ☐ NO

DSMES PLAN:

Please check all areas that you are most interested in learning about:

☐ What is Diabetes ☐ Healthy Coping ☐ Healthy Eating ☐ Being Active

☐ Taking Medications ☐ Reducing Risk ☐ Monitoring ☐ Problem Solving

☐ Other: _____

List goals, questions, or concerns for your DSMES Team: _____

_____

_____