**Diabetes management assessment**

Indian Health Care Resource Center of Tulsa, Inc.

|  |
| --- |
| **DIABETES MANAGEMENT ASSESSMENT** |
| **Chart # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_ Marital Status:** Single Married Widowed Divorced |
| ***PERSONAL INFORMATION*** |
| Do you live alone? YES NO |
| How long have you had diabetes or high blood sugar? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Does anyone else in your family have diabetes? YES (Who?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) NO |
| Have you had diabetes education before? YES NO When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Educator? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have trouble getting diabetes supplies or medicines? YES NO |
| If yes, why? \_\_\_\_ Cost \_\_\_\_ transportation \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you feel your diabetes is in good control? YES NO |
| If no, where do you think you need help? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***HEALTH HISTORY*** |
| **Are you being treated for any of these things?** (Place a check on all lines that apply) |
| \_\_\_\_\_ High blood pressure Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Heart disease Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Eye disease Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Allergies Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ High cholesterol/triglycerides Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Depression Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Kidney Disease Medicine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ Other health problems:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Do you have any of these problems at this time?** |
| \_\_\_\_\_ Stomach problems (bloating, feeling full) \_\_\_\_\_ Changes in weight or appetite |
| \_\_\_\_\_ Numbness, pain or tingling in the feet \_\_\_\_\_ Trouble sleeping |
| \_\_\_\_\_ Any sores that won’t heal \_\_\_\_\_ Diarrhea or constipation |
| \_\_\_\_\_ Feeling tired or weak \_\_\_\_\_ Personality changes  |
| \_\_\_\_\_ Sexual problems - Would you like information? YES NO |
| **Do you smoke?** YES NO If yes, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Would you like information on quitting? YES NO |
| **Do you use ceremonial tobacco? YES NO** |
| **Do you see a traditional healer when you are sick?** YES NO |
| **Do you drink alcohol?** YES NO If yes, how many drinks per: \_\_\_\_\_ Day \_\_\_\_\_ Week |
| **When was** your last complete physical \_\_\_\_\_\_\_\_ Who did it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **When was** your last diabetes eye exam? \_\_\_\_\_ Were your eyes dilated? YES NO Was it normal? YES NO |
| **When was** your last dental exam? \_\_\_\_\_\_\_\_\_\_\_\_ Do your gums bleed? YES NO |
| Have you been to an emergency room, urgent care or hospital for your diabetes in the last year? YES NO |

|  |
| --- |
| **DIABETES MANAGEMENT ASSESSMENT, PAGE 2** |
| ***DIABETES MEDICINES*** |
| **Do you take pills for your diabetes? YES NO Do you take Byetta? YES NO** (Dose \_\_\_\_\_\_\_\_\_) |
| Name of pill(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How much \_\_\_\_\_\_\_\_\_\_\_ Time(s) of day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many times a week do you: \_\_\_\_\_\_\_\_\_Miss a dose? \_\_\_\_\_ Take it more than an hour late? |
| **Do You Take Insulin? YES (Show all the types you take by circling below ) NO**  |
| Humalog Novolog Apidra Lantus Levemir NPH Pre-mixed (Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |
| How much do you take? (Please list type and amount of each insulin by time of day) |
| Morning insulin dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Time \_\_\_\_\_\_\_\_\_\_\_\_ |
| Noon/lunchtime insulin doe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Time \_\_\_\_\_\_\_\_\_\_\_\_ |
| Dinnertime insulin dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Time \_\_\_\_\_\_\_\_\_\_\_\_ |
| Bedtime insulin dose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Usual Time \_\_\_\_\_\_\_\_\_\_\_\_ |
| Where do you give your shots (circle all that apply) Arms Legs Abdomen Other \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any itching, swelling, hardness or other reactions at your injections sites? YES NO |
| Do you adjust the amount of insulin you take? YES (If Yes, is it Often Occasionally Rarely) NO |
| How many times a week do you: \_\_\_\_\_\_\_ Miss a dose? \_\_\_\_\_ Take it more than an hour late? |
| Where do you keep: insulin you’re using now? \_\_\_\_\_\_\_\_\_\_\_\_\_ Extra insulin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  **Do you take Symlin? YES** (Dose \_\_\_\_\_) **NO** |
| ***MONITORING*** |
| Do you check your own blood sugar? YES NO  I don’t have a meter and/or strips |
| Which meter do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you having any problems with it? YES NO |
| How often do you check your blood sugar? \_\_\_\_\_\_\_\_\_ times per day \_\_\_\_\_\_\_ times per week |
| When do you usually check it? \_\_\_\_\_ First thing in the morning \_\_\_\_ Before meals \_\_\_ After mealsIs there a reason you don’t check your blood sugar? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What is your usual or average morning blood sugar, before eating? \_\_\_\_\_\_\_\_\_ After meals? \_\_\_\_\_\_\_\_\_\_\_ |
| Do you keep a record of your numbers? YES NO Do you know your HbA1c? YES (\_\_\_\_\_ latest %) NO |
| Do you check ketones? YES (do you use: \_\_\_\_\_ Urine strips? \_\_\_\_ Precision Xtra Meter? ) NO  |
|  |
| ***LOW BLOOD SUGAR*** |
| Do you ever have low blood sugar? YES NO DON’T KNOW |
| If Yes, how many times a week? \_\_\_\_\_ How many times a month? \_\_\_\_  |
| How do you know you are getting low? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What do you eat or drink when you are too low? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you carry these things with you? YES NO Where (else) do you keep them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you wear or carry Medical ID (jewelry or card)? YES NO |
| Have you ever passed out from low blood sugar? YES NO If Yes, when was the last time? \_\_\_\_\_\_\_\_\_  |
| If you use insulin, do you have a Glucagon Emergency kit? YES NO  Don’t know what it is |

|  |
| --- |
| **DIABETES MANAGEMENT ASSESSMENT, PAGE 3** |
| ***ACTIVITY*** |
| How many times per week are you physically active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How long do you exercise each time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What time of day are you most likely to be active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What kind of exercise do you usually do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any favorite activities you do for fun? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you get short of breath when you exercise? YES NO Get pains in your legs? YES NO |
| Do you have low blood sugars when you are doing something active? YES NO |
| ***FOOD AND NUTRITION*** |
| Do you follow a particular meal plan or guidelines for your diabetes? YES NO |
| If Yes, please describe it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you try to limit (circle any that apply)? Salt Sugar Potassium Protein Fat Fiber |
| Do you try to eat more (circle any that apply) Potassium Protein Fiber Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you have any food allergies? YES (please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) NO |
| How many meals do you usually eat per day? \_\_\_\_\_\_\_ How many snacks? \_\_\_\_\_\_\_ |
| How many times a week do you miss or delay a meal or snack? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Religious/tribal observances/food restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Do you shop at the (check all that apply) grocery store \_\_\_ convenience store \_\_\_ farmer’s market \_\_\_ |
| Do you take any vitamin, mineral or herbal supplements? YES ( list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) NO |
| Are you able to purchase healthy foods? YES NO |
| How many meals do you eat away from home in an average week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you want to lose weight? YES NO |
| Do you ever eat uncontrollably (binge)? YES (how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ) NO |
| How do mood changes or stress effect your eating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ***FOOT CARE*** |
| Do you know how to check your feet for diabetes-related problems? YES NO |
| How often do you check your feet? Rarely or Never Sometimes Often Daily |
| Do you have any physical problems that prevent you from checking? YES NO |
| If Yes, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| When was the last time your doctor or podiatrist checked your feet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you take your shoes and socks off each time you see your doctor? YES NO  |
| Do you see a podiatrist? YES (How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_) NO – If yes, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you walk around barefoot? YES NO |
| Have you had any surgeries for diabetes-related foot problems? YES NO |
| If Yes, what was done and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |
| --- |
| **DIABETES MANAGEMENT ASSESSMENT, PAGE 4** |
| ***DIABETES AND EMOTIONS*** |
| Diabetes affects the whole person. Most people feel sad, angry or overwhelmed at times because of it. If you are having any of these types of feelings, it is important to recognize and identify them. Circle any of the words below that describe how you currently feel about your diabetes: |
| Overwhelmed Out of control Hassled Burdened Alone Angry OK Satisfied |
|  |
| Depression is much more common in people with diabetes than in others. If you are depressed, it is very difficult to focus on taking care of your diabetes. The following questions ask about common signs of depression. Please answer each one YES or NO.  |
| Have you been feeling sad or depressed? ………………………………………… YES NO |
| Are you getting less pleasure from your job, sports or hobbies? …………………. YES NO |
| Do you often feel tired for no apparent reason? …………………………………. YES NO |
| Do you have trouble sleeping or sleep too much? ………………………………. YES NO |
| Have you been gaining or losing weight without trying? …………………………YES NO |
| Do you often feel down on yourself, like everything is your fault? ………………YES NO |
| Do you have trouble concentrating or making decisions? ……………………….. YES NO |
| Do you often feel agitated or like you can barely move? …………………………YES NO |
| Do you ever feel that life isn’t worth living? …………………………………….. YES NO |
|  |
| What is your greatest fear about diabetes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| ***GETTING THE MOST OUT OF YOUR CLASSES*** |
| Do you have any condition that affects your ability to take part in class or to learn? YES NO |
| If Yes, please call our office to discuss your needs before the first class. |
|  |
| This program should help you with the things that concern you most about your diabetes. Please list three things you want to learn or change about your diabetes in this program: |
| 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Patient’s Signature Date |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Educator’s Signature Date |