**DIABETES SELF-MANAGEMENT ASSESSMENT**

Name (last, first) ____________________________________________ Date of Birth _____/____/____ Today's Date _____/____/____

**PERSONAL INFORMATION**

Living status:  □ Single  □ Married  □ Divorced  □ Widowed  □ Separated  □ Living with a partner

When were you first told you have diabetes? ____________________  □ I don’t really think I have diabetes.

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

Have you had diabetes education in the past?  □ Yes  □ No  If yes, what year? ___________________________

Do you have any cultural or spiritual practices of which you would like to make us aware that would impact the treatment/education plan we would provide to you?  □ Yes  □ No

If yes, please explain: __________________________________________________________________________

**GENERAL HEALTH HISTORY**

Please tell us the date of your last:

- Complete physical exam by your primary care doctor ______/____/____
- Dental exam ______/____/____  Dilated eye exam ______/____/____  Podiatry (foot doctor) exam ______/____/____
- Flu vaccination ______/____/____  Pneumonia vaccination ______/____/____

Hospitalizations/surgeries in last five years (date/reason):

(Female only) Mammogram ______/____/____  PAP smear ______/____/____  History of gestational diabetes?  □ Yes  □ No

Are you pregnant?  □ Yes  □ No  Are you considering pregnancy?  □ Yes  □ No

(Male only) Digital rectal exam ______/____/____

Please check all that apply and explain.

- □ Eye or vision problems ____________________________________________________________________ □ Dental or mouth problems __________
- □ Sleep apnea □ Problems with sleeping ______________________________________________________
- □ Changes in appetite/weight ________________________________________________________________ Height ______ Usual Body Weight (lb) ______
- □ Frequent (circle) nausea, vomiting, constipation, or diarrhea ____________________________
- □ High blood pressure □ Stroke □ Heart disease □ High cholesterol/lipids/blood fats
- □ Foot problems __________________________________________ □ Numbness/pain/tingling in feet
- □ Circulation problems __________________________________________ □ Open sores on skin
- □ Thyroid disease _____________________________________ □ Kidney/bladder problems ___________ □ Liver problems ___________
- □ Feelings of tiredness/weakness □ Depression □ Problems with sexual function

Other problems ____________________________________________________________________________

Do you smoke?  □ Yes  □ No  If yes, how much per day? ______ would you like information on quitting?  □ Yes  □ No

Do you drink alcohol?  □ Yes  □ No  If yes, how much per day? ____________________________________

Do you take street drugs?  □ Yes  □ No  If yes, please explain ____________________________________

During the past month:

1. Have you often been bothered by feeling down, depressed, or hopeless?  □ Yes  □ No
2. Have you been bothered by little interest or pleasure in doing things?  □ Yes  □ No
3. Are you involved in therapy with a counselor or psychologist?  □ Yes  □ No
DIABETES SELF-MANAGEMENT ASSESSMENT

Name (last, first) ____________________________________________________________ Date of Birth ___/___/___ Today’s Date ___/___/___

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Geckle Diabetes and Nutrition Center
6565 N. Charles St., Suite 507
Baltimore, MD 21204
P: 443-849-2036  F: 443-849-8999

NUTRITION/DAILY ROUTINE

What food planning methods have you followed in the past? (check all that apply)

- Calorie counting
- Exchange lists
- Food pyramid/healthy choices
- Low carbohydrate
- Carbohydrate counting
- Fat gram counting
- No added sugar
- No method
- Plate method/portion control
- Other ______________________________________________________________

What method of diabetes food planning (if any) are you currently using? ____________________________

How often do you follow a diabetes food plan?  □ 0  □ 1-25%  □ 26-50%  □ 51-75%  □ >75%

Please fill in/circle the times of your meals and snacks, along with an example of the type and amount of food you might eat in one day. Example: Time: 3:00-4:00 PM  Typical Meals/Snacks: small bag potato chips, one bottle sweet iced tea

My Usual Routine | Time | Typical Meals/Snacks for One Day
--- | --- | ---
I get up most days at | AM | 
Breakfast | AM | 
| PM | 
Morning snack | AM | 
| PM | 
Lunch | AM | 
| PM | 
Afternoon snack | AM | 
| PM | 
Evening meal | AM | 
| PM | 
Bedtime snack | AM | 
| PM | 
I go to bed most days at | AM | 

Food Preferences  □ Vegetarian  □ Ethnic  □ Other

Food Allergies/Intolerances  □ Yes  □ No  If yes, please list: ___________________________________________

What specific eating concerns do you have?  □ Heartburn  □ Nausea  □ Vomiting  □ Constipation  □ Diarrhea  □ Loss of appetite  □ Weight loss (losing weight without trying)  □ Weight gain  □ Other __________________________

ACTIVITY/EXERCISE

Has your doctor told you to limit your exercise in any way?  □ Yes  □ No  If yes, explain ________________________________

What kind of exercise do you do?  □ Walking  □ Biking  □ Swimming  □ Aerobic machine  □ Sports  □ Active job  □ Other __________________________________________________________

How many times per week do you exercise?  □ 0  □ 1-2  □ 3-4  □ 5-6  □ >6

How many minutes do you exercise each time?  □ 0  □ 1-15  □ 15-30  □ 30-45  □ 45-60  □ >60

What time of day do you exercise?  __________________

INSULIN USERS ONLY  I use an insulin-to-carbohydrate ratio.  □ Yes  □ No

If yes, please write in your ratio for each meal/snack below.  Example: Breakfast: 1:15

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Morning Snack</th>
<th>Lunch</th>
<th>Afternoon Snack</th>
<th>Evening Meal</th>
<th>Bedtime Snack</th>
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I use a correction/sensitivity factor to lower my blood glucose (1 unit of insulin lowers my blood glucose ___ mg/dL).  □ Yes  □ No  If yes, please write in your correction/sensitivity factor(s) below.  Example: Daytime: 50 mg/dL.

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DIABETES SELF-MANAGEMENT ASSESSMENT

Name (last, first) ____________________________ Date of Birth ___/___/___ Today’s Date ___/___/___

INSULIN PUMP USERS ONLY Please write in your standard daily basal rates.

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LIFESTYLE AND BEHAVIORAL CONCERNS THAT MIGHT AFFECT MY ABILITY TO TAKE CARE OF MY DIABETES

Check all that apply.

☐ Financial issues       ☐ Language barriers       ☐ Coping issues       ☐ Depression
☐ Insurance issues       ☐ Mobility issues       ☐ Family life/home issues
☐ Transportation issues  ☐ Job issues/work schedule ☐ Too busy to manage my diabetes

What do you feel are your most important concerns in managing your diabetes? ________________________________________________________________

What would you like to learn during your visits? ________________________________________________________________

PAIN  If you are in any kind of pain TODAY, please rate your pain on a scale of 1 (low) to 10 (high) and provide details.

Pain level ______ Details ________________________________________________________________

MONITORING

Do you have a target blood glucose range?  ☐ Yes ☐ No  If yes, what is it? __________________________ mg/dL

Do you know what an A1C level is?  ☐ Yes ☐ No  Do you have a target A1C?  ☐ Yes ☐ No  If yes, what is it? ____%

Do you know what your last A1C was?  ☐ Yes ☐ No  If yes, date ___/___/___ Result ____%

Do you check your blood glucose?  ☐ Yes ☐ No

How often do you check your blood glucose?  Times a day ______  Times per week ____________

When do you check your blood glucose?  ☐ Before meals ☐ After meals ☐ Other ______________________

What are your usual blood glucose ranges?  Before eating? ______________________  After eating? ______________________

Name of your glucose meter: ___________________

For people with type 1 diabetes only:  Do you ever check for ketones?  ☐ Yes ☐ No  ☐ I don’t know what ketones are.

When do you check for ketones? ________________________________________________________________

HYPOGLYCEMIA (LOW BLOOD GLUCOSE) HISTORY

Do you ever have low blood glucose?  ☐ Yes ☐ No  ☐ I don’t know

Do you get symptoms when your blood glucose gets low?  ☐ Yes ☐ No

If yes, what kind of symptoms do you get? ________________________________________________________________

How many times per week? ________________  How many times per month? ________________

What do you use to treat low blood glucose? ________________________________________________________________

Do you always carry something with you to treat low blood glucose?  ☐ Yes ☐ No

Do you wear a medical alert bracelet or necklace?  ☐ Yes ☐ No

Have you ever passed out from low blood glucose?  ☐ Yes ☐ No  If yes, when was the last time? ____________
DIABETES SELF-MANAGEMENT ASSESSMENT

Name (last, first) ___________________________________________ Date of Birth ___/___/___ Today’s Date ___/___/___

MEDICATIONS

Medication allergies and reactions (please list): ________________________________________________________________

CURRENT MEDICATIONS (include over-the-counter and herbal medications)

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MEDICATION RECONCILIATION

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