PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

Name: _______________________________  Date: _______________________________

1. What type of diabetes do you have?  ❑ Type 1  ❑ Type 2  ❑ Pre-Diabetes  ❑ Gestational (GDM)  ❑ Don't Know
2. Year/Age of Diabetes Diagnoses: ______/______  List relatives with diabetes: ____________________________________________
3. What is the last grade of school you have completed? ______________________________________________________
4. Are you currently employed?  ❑ Y  ❑ N  What is your occupation? ____________________________________________
5. How many people live in your household? ______________________________________________________________
6. How are they related to you? _____________________________________________________________
7. From whom do you get support for your diabetes?  ❑ Family  ❑ Co-workers  ❑ Healthcare providers  ❑ Support group
   ❑ No-one
8. Do you have a meal plan for diabetes?  ❑ Y  ❑ N  If yes, please describe: ____________________________
9. Do you read and use food labels as a dietary guide?  ❑ Y  ❑ N
10. Do you have any diet restrictions:  ❑ Salt  ❑ Fat  ❑ Fluid  ❑ None  ❑ Other ______________________________________
11. Give a sample of your meals for a typical day:
   Time: __________ Breakfast: ____________________________
   Time: __________ Lunch: ______________________________
   Time: __________ Dinner: ______________________________
   Time: __________ Snack: ________________________________

12. How often do you eat out? ________________________________________________________________
13. Do you drink alcohol?  ❑ Y  ❑ N  Type: _________  How many: _________ per day  ❑ per week  ❑ occasionally
14. Do you use tobacco?  ❑ cigarette  ❑ pipe  ❑ cigar  ❑ chewing  ❑ none  ❑ quit _________ how long ago
15. My exercise routine is:  ❑ Easy  ❑ Moderately Intense  ❑ Very Intense
16. Do you use any exercise equipment?  ❑ Yes  ❑ No
17. Check any of the following test/procedures you have had in the last 12 months:
   ❑ dilated eye exam  ❑ urine test for protein  ❑ foot exam  ❑ healthcare professional  ❑ dental exam  ❑ blood pressure
   ❑ weight  ❑ cholesterol  ❑ HgA1c  ❑ flu shot  ❑ pneumonia shot
18. In the last 12 months, have you:  ❑ used the emergency room services  ❑ been admitted to a hospital
19. Have you had previous instruction on how to take care of your diabetes?  ❑ Y  ❑ N  How long ago? _________
20. How do you learn best:  ❑ Listening  ❑ Reading  ❑ Observing  ❑ Doing?
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22. Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes?  □ Y  □ N
Please describe: __________________________________________________________

23. Do you use computers: □ to email □ look for health and other information

24. Pregnancy and Fertility: (Men please skip to #25)
Last menstrual period? ______________________
Are you pregnant? □ Y  When are you expecting? __________ □ N Are you planning on becoming pregnant? __________

Have you been pregnant before? □ Y  □ N  Do you have any children? □ Y  Ages__________________ □ N
Are you aware of the impact of diabetes on pregnancy? □ Y  □ N

Are you using birth control? □ Y  please specify __________________________________________ □ N

25. Please state whether you agree, are neutral or disagree with the following statements:
I feel good about my general health: □ agree □ neutral □ disagree
My diabetes interferes with other aspects of my life: □ agree □ neutral □ disagree
My level of stress is high: □ agree □ neutral □ disagree
I have some control over whether I get diabetes complications or not: □ agree □ neutral □ disagree
I struggle with making changes in my life to care for my diabetes: □ agree □ neutral □ disagree

26. 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

27. How do you handle stress? __________________________________________________________

28. What are your thoughts or concerns about diabetes? ________________________________

29. What are you most interested in learning from these diabetes education sessions? ________________________

Provider Reviewing this form with Patient: ________________________________________________ Page 2 of 3
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PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

MEDICATIONS: (Please complete if you have NOT been a patient at GBMC in the past 6 months or if you have entered your current medications into the patient portal)

Medication allergies and reactions (please list): ____________________________________________________________

CURRENT MEDICATIONS (include over-the-counter and supplements)

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