Geckle Diabetes and Nutrition Center
6701 N. Charles St., Suite 2372
Baltimore, MD 21204
P: 443-849-2036 F: 443-849-8999

PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

Name: ____ Date: _______________________________

Date of Birth: ______________

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:____

About how often do you use this meal plan? ❑Never ❑Seldom ❑Sometimes ❑ Usually ❑ Always

Do you read and use food labels as a dietary guide? ❑Y ❑N

Do you have any diet restrictions: ❑Salt ❑Fat ❑Fluid ❑None ❑Other _______________________________________

Give a sample of your meals for a typical day:

Time: ___________ Breakfast: ____

Time: ___________ Lunch: ____

Time: ___________ Dinner: ____

Time: ___________ Snack: ____

9. Do you: do your own food shopping? ❑Y ❑N Cook your own meals? ❑Y ❑ N

How often do you eat out? ____

10. Do you drink alcohol? ❑ Y ❑ N Type: ___________ How many: ___________ ❑per day ❑ per week ❑ occasionally
11. Do you use tobacco? ❑ cigarette ❑pipe ❑cigar ❑chewing ❑none ❑quit ________how long ago
12. Do you exercise regularly? ❑Y ❑N Type: ______________________________ How often: ________________________

My exercise routine is: ❑ Easy ❑Moderately Intense ❑ Very Intense

13. Do you check your blood sugars? ❑Y ❑N Blood Sugar range: __________ to __________

How often: ❑ Once a day ❑ 2 or more/day ❑ 1 or more/Week ❑Occasionally

When: ❑ Before breakfast ❑ 2 hours after meals ❑ Before bedtime

14. In the last month, how often have you had a low blood sugar reaction: ❑ Never ❑ Once ❑ One or more times/week

What are your symptoms? ____

15. Can you tell when your blood sugar is too high? ❑ Y ❑ N

What do you do when your sugar is high? ____

16. 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

17. In the last 12 months, have you: ❑ used the emergency room services ❑ been admitted to a hospital

Was ER visit or hospital admission diabetes related? ❑ Y ❑ N

18. Do you have any of the following problems? ❑ eye problems ❑ kidney problems ❑dental problems ❑depression ❑ numbness/tingling/loss of feeling in your feet ❑high blood pressure ❑ high cholesterol ❑sexual problems

18b. Are you having pain today? ❑ Y ❑ N; Location of pain __________; Severity 1-10 ________.

Is this pain chronic? ❑ Y ❑ N; If yes, who is the physician managing your pain? ______________________

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?

Provider Reviewing this form with Patient: ____

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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? _________________________

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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)

MEDICATION NAME	DOSE/FREQUENCY	REASON

Provider Reviewing this form with Patient: ____