Name: _____ Age: _____

Today's Date: _____ Date of Birth: _____

Email Address: _____

Primary Physician: _____

DuPage Medical Group

WE CARE FOR YOU

Diabetes Assessment Form

Socioeconomic Background

- **Ethnicity**:
  ☐Caucasian ☐ African American ☐ Hispanic ☐Native American ☐Asian ☐ Middle Eastern
- **Language preference**:
  ☐English ☐Other _____
- **Education completed**:
  ☐Less than 8th grade ☐Some high school ☐High school ☐Some college/tech ☐ College ☐ Post college
- **Employment**:
  Are you currently employed? ☐No ☐Yes What is/was your occupation? _____
- **Marital Status**:
  ☐Single ☐Married ☐Divorced ☐Widowed
- **Disabilities / difficulty with**:
  ☐Hearing ☐Seeing ☐Reading ☐Speaking ☐ Physical ☐ Psychological ☐ None
  Explain any checked: _____
- **Learning Style**:
  Do you prefer to learn by: ☐Listening ☐ Reading ☐Observing ☐Doing
- **Support System**: From whom do you get support for your diabetes?
  ☐Family ☐Co-workers ☐Healthcare providers ☐Support group ☐No-one
- **Cultural / Religious Beliefs:** Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ☐No ☐Yes If yes, please describe_____

Health History

Check box if you've ever had any of the following conditions:

☐	Breathing Problems	☐	Heart Problems		☐	Blurred Vision
☐	Cancer	☐	Kidney Disease		☐	Fatigue
☐	Cataracts / Glaucoma	☐	Pain Issues		☐	Frequent / recent infections
☐	Circulation Problems	☐	PCOS		☐	Hunger
☐	Depression / Mental Illness	☐	Sleep Apnea		☐	Numbness / tingling
☐	Gestational Diabetes	☐	Stroke		☐	Slow healing cuts or sores
☐	Foot Problems	☐	Stomach / Intestinal Problems		☐	Sexual Dysfunction
☐	High Blood Pressure	☐	Thyroid Problems		☐	Frequent Thirst
☐	High Cholesterol	☐	Other:		☐	Frequent Urination

Do you have any of the following:

- Do you follow any special diet for the above conditions? ☐ No ☐ Yes—please list _____
- When was your last dilated eye exam? Month____Year____
- Have you seen a foot doctor? ☐ No ☐ Yes When? Month_____Year____ Do you check your feet daily? ☐ No ☐ Yes
- Do you drink alcohol? ☐ No ☐ Yes How many drinks *per week*? Wine: ____ Beer _____ Mixed Drinks _____
- Do you smoke? ☐ No ☐ Yes Did you ever smoke? ☐ No ☐ Yes When did you quit?_____
  How much do/did you smoke? _____packs per day for _____number of years

Diabetes History

- Type of Diabetes: ☐ Type 1 ☐Type 2 ☐Pre-Diabetes ☐Don't know. When were you diagnosed? Month _____Year _____
- Does anyone in your family have diabetes? ☐ No ☐ Yes. If yes, whom? _____
- Have you had previous diabetes education? ☐No ☐Yes--From whom? ☐ DuPage Medical Group ☐Other _____
- In your own words, what is diabetes? _____

_____

- What are you most interested in learning from these diabetes education sessions?

  ☐Healthy Eating ☐ Impact of Physical Activity ☐Using Medications ☐Checking My Blood Sugar

  ☐Behavior Change Strategies ☐Lowering My Risk for Complications ☐Coping Skills

Testing Your Blood Sugar:

- Do you test your blood sugar at home? ☐ No ☐ Yes. If yes: What meter do you use? _____
- How often do you test your blood sugar each day? (circle one) 1 2 3 4+ times per day Other _____
- When do you test? ☐Before breakfast ☐Before lunch ☐Before dinner ☐Bedtime

  ☐2 hours after breakfast ☐2 hours after lunch ☐2 hours after dinner ☐Other_____
- In the last month, how often have you had a **low blood sugar reaction?** ☐Never ☐Once ☐ Two or more times/week
- What do you do when your blood sugar is too high? _____
- What do you do when your blood sugar is too low? _____
- In the last 12 months, have you been to an emergency room for a diabetes related event? ☐ No ☐ Yes

Pregnancy: Have you ever been pregnant? ☐ Not applicable ☐No ☐Yes
If yes; please fill in chart below:

Child's birth year					
Child's birth weight					
Did you have gestational diabetes?	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

Emotions and Diabetes

Please check whether you agree, are neutral or disagree with these statements:

	Yes	No	Comments
I feel good about my general health.			
My level of stress is high.			
My diabetes interferes with other aspects of my life.			
I have some control over whether I get diabetes complications.			
I struggle with making changes in my life to care for my diabetes.			

- What concerns you most about your diabetes? _____
- What is hardest for you in caring for your diabetes? _____

Diabetes Medications

Medications you take for Diabetes: ☐ No ☐ Yes If yes, pills or injections taken *for diabetes*:

Name of Medication	Dose	Time(s) taken?

Medication Behavior

- In a typical week, how often do you forget to take your medicine? _____ times per week / month (circle)
- When you feel better, do you sometimes stop taking your medicine? ☐ No ☐ Yes
- Sometimes if you feel worse when you take the medicine, do you stop taking it? ☐ No ☐ Yes

Medication Beliefs

- Do you think your medications can help you control your diabetes and better your health? ☐ No ☐ Yes
- Do you know about why these medications have been recommended and how they work? ☐ No ☐ Yes

Medication Constraints

- Do you ever cut back on your medications because of out of pocket costs? ☐ No ☐ Yes
- Do you ever feel confused or overwhelmed about when to take your medication? ☐ No ☐ Yes

Nutrition & Exercise History

- Height: _____ Weight: _____ Has your weight changed in the last year? ☐ No ☐ Yes
  What do you think is a realistic weight for you?_____ lbs. How long since you were at that weight? _____
- Rate your CONFIDENCE in your ability to make dietary changes (1=low; 10=high) 1 2 3 4 5 6 7 8 9 10
- Rate your MOTIVATION level for making dietary changes (1=low; 10=high) 1 2 3 4 5 6 7 8 9 10
- Do How many times a week do you eat out for: Breakfast _____ Lunch _____ Dinner _____
  Types of places you eat out at: _____ fast food _____ café _____buffets _____take out _____fine dining
- What types of beverages do you drink during the day?_____
- Do you eat regular meals? ☐ No ☐ Yes Comments:_____
- Do you take any vitamins, minerals or other diet supplements? ☐ No ☐ Yes
- If yes, what?_____
- For these statements, please say if often true, sometimes true, or never true for you/your household in the last 12 months.
  - "We worried whether our food would run out before we got money to buy more."
    Please circle one: OFTEN, SOMETIMES, or NEVER true for you in the last 12 months?
  - "The food that we bought just didn't last and we didn't have money to get more."
    Please circle one: OFTEN, SOMETIMES, or NEVER true for you in the last 12 months?
- Do you exercise now? ☐ No ☐ Yes

If Yes, what do you do and how often do you do it?

Type of exercise you do:	Amount of time you do it:	Times per week you exercise:

STAFF ONLY

Reviewed by:_____ Date:_____

PATIENT LABEL