



## Initial Patient Self-Assessment

### Demographics:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender:  Male  Female  Other

Primary Language:  English  Spanish  Other \_\_\_\_\_

### Occupation:

Clerical  Skilled Labor  Sales  Homemaker  
 Professional/Managerial  Student  Other Labor  
 Disabled  Retired  Unemployed  Other \_\_\_\_\_

### Education:

Elementary School  Some High School  High School Degree  
 Some College  College Degree  Post Graduate

### Race/ Ethnicity:

White / Caucasian  Black/African American  Hispanic/Latino/Mexican  American Indian  
 Asian / Chinese/ Japanese / Korean  Native Hawaiian or other Pacific Islander  Alaska Native  
 Other \_\_\_\_\_

## Introduction

Have you ever been diagnosed, ever been told, or have you had problems with the following?(mark all that apply)

High Blood Pressure  Heart Disease / Chest Pain Stroke  High Cholesterol  
 Thyroid Disease  Problems with sexual function  Kidney / Bladder problems  
 Asthma or Shortness of Breath  Eye or vision problems  Numbness/pain/tingling of hands/feet  
 Other foot problems  Frequent nausea, vomiting  constipation, diarrhea  Depression or anxiety  
 Other health problems  Surgery in the last 5 years  Drug allergies

What is your height? \_\_\_\_\_ Feet \_\_\_\_\_ inches

What is your current weight? \_\_\_\_\_ lbs.



**In the past year have you?**

- Lost more than 10 lbs.       Gained more than 10 lbs.       Stayed about the same

**During what year were you diagnosed with diabetes?** \_\_\_\_\_

**Have you had diabetes education?**     Yes     No

**If yes, when (month and year)?** \_\_\_\_\_

**Do you have any physical limitations that may affect your ability to perform your self-care? (check all that apply)**

- Hearing problems       Problems with the use of your hands       Problems with the use of your feet  
 Vision loss (not corrected by glasses or contacts)

**How do you learn best? (check all that apply)**

- Listening       Watching       Hands On/Doing

**Number of emergency room visits or 911 calls for your diabetes requiring assistance in the last three months:** \_\_\_\_\_

**Number of days missed from work, school or usual routine because of diabetes within the last 30 days:** \_\_\_\_\_

**Number of hospital admissions for diabetes within the last 3 months:** \_\_\_\_\_

Having diabetes means that you need to make choices about food, physical activity, and when and how to take medicines. You may need blood tests and other exams to monitor your diabetes health status. You also need to do things to prevent problems related to your health, know how to cope with your diabetes, and make everyday management decisions.

The following questions are about the things you need to do to stay healthy with your diabetes. These questions ask about the things you do, how often you do them, how important they are to you and how sure you are about doing them.

## **Reducing Risks**

Reducing risks means that you are taking steps to prevent or reduce problems related to diabetes. This includes having eyes checked by an eye doctor, having feet checked by a health care provider, seeing a dentist, getting flu and/or pneumonia vaccinations, having blood pressure checked, having cholesterol and triglycerides checked, and not smoking.

**Check all of the following things that have happened in the past year.**

- Had an eye exam (with drops in the eyes) by an eye doctor     Saw a dentist  
 Had feet checked by a health care provider     Had a flu and/or pneumonia vaccination  
 Had blood pressure checked     Had cholesterol and triglycerides checked  
 Had an A1C test     Got help to stop smoking (only applicable for smokers)



**How important do you feel it is to do the things listed above to help prevent or reduce problems related to diabetes, where 0 is not important at all and 5 is very important?**

0      1      2      3      4      5

**How often does life stress make it hard for you to perform diabetes self-care, where 0 is not at all and 5 is very likely?**

0      1      2      3      4      5

**How often do you closely examine or look at your feet with your socks off?**

Daily       Several times a week       A few times a month       Once in a while       Rarely or never

**How sure are you that you can get the help you need to prevent or reduce problems related to diabetes?**

(0 is not sure at all and 5 is very sure)

0      1      2      3      4      5

**Result of my A1C test as given to me by the health care provider: \_\_\_\_\_**

**Are you able to become pregnant? \_\_\_\_\_ If so, when was the last time you had counseling about what to do before getting pregnant (if female and able to get pregnant)?**

Never       Last 6 months       Last year       Over a year ago       Do not know

### **Being Active**

Being active means you are taking part in doing things such as jogging, bicycling, golfing, gardening, or walking without stopping for at least 30 minutes most days of the week.

**During the past week, or last 7 days, how many days were you able to be active? (circle one)**

0      1      2      3      4      5

**How important is it to you to be active, where 0 is not important at all and 5 is very important?**

0      1      2      3      4      5

**How sure are you that you can be active, where 0 is not sure at all and 5 is very sure?**

0      1      2      3      4      5

### **Healthy Eating**

Following an eating plan that is good for you includes: not eating too much, counting the amount of carbohydrates you eat, not eating too much fat, keeping an eye on and/or drinking less alcohol. It also means eating fruits, vegetables, whole grains, and beans and other foods with high fiber. Following an eating plan that is good for you may also include reaching goals for losing weight, and limiting the amount of protein and salt you eat.

**During the past week, or last 7 days, how many days were you able to follow a healthy eating plan? (circle one)**

0      1      2      3      4      5

**How sure are you that you can follow an eating plan that is good for you, where 0 is not sure at all and 5 is very sure? (circle one)**

0      1      2      3      4      5



How important is it to you to follow an eating plan that is good for you, where 0 is not important at all and 5 is very important? (circle one)

0      1      2      3      4      5

## Taking Medication

Taking medication means that you take medicines that have been prescribed by your healthcare provider to treat your diabetes or other health conditions. These may be pills, insulin, creams, or other medicines that you inject.

**Please answer for all the medicines that you take.**

Do you take diabetes medication? (Check all that apply)

Pills     Insulin     Other injections for blood sugar     Do not take medication

Do you take any additional nutritional supplements? (Check all that apply)

Vitamins     Herbal supplements     Other \_\_\_\_\_

Sometimes it can be a hard to remember to take all of your medicines. Over the past week, or last 7 days, how many days have you missed taking your diabetes medicines as recommended?

0      1      2      3      4      5

How important is it to you to take your medicines, where 0 is not important at all and 5 is very important?

0      1      2      3      4      5

How sure are you that you can take your medicines, where 0 is not sure at all and 5 is very sure?

0      1      2      3      4      5

## Monitoring

Monitoring for people with diabetes means that they regularly check blood sugar. Monitoring also includes checking your blood pressure, cholesterol, and weight. For this set of questions, we will focus on blood sugar monitoring. Monitoring the level of your blood sugar means that you use a blood sugar meter to take a blood sugar reading. Monitoring may be done on your own or with the help of a health care provider.

During the past week, or last 7 days, how many days were you able to monitor your blood sugar at least once per day?

0      1      2      3      4      5

How important is it to you to monitor your blood sugar at least once per day, where 0 is not important at all and 5 is very important?

0      1      2      3      4      5

How sure are you that you can monitor your blood sugar at least once per day, where 0 is not sure at all and 5 is very sure?

0      1      2      3      4      5



**How often do you have *high* blood sugar?**

- Daily Several times a week     A few times a month     Once in a while  
 Rarely or never     Don't know

**How often do you have *low* blood sugar?**

- Daily Several times a week     A few times a month     Once in a while  
 Rarely or never     Don't know

**Do you wear a bracelet or keep something with you to identify that you have diabetes?**     Yes     No

**Do you use a meter to check your blood sugar?** (check one)     Yes     No

**How often do you usually check your blood sugar?**

- 4 or more times a day     3 times a day     2 times a day     Once a day  
 Once a week or less     Rarely or never

**Problem Solving**

Problem solving means coming up with ways to make every day and/or challenging decisions to stay healthy with your diabetes. When you make a decision about what to eat or how much to eat, choose which medicines to take, decide whether to take a walk, or determine how you're going to make changes to your daily routine to help your diabetes, you are problem solving. For most situations this means figuring out the problem, finding a way to deal with it and thinking about what may prevent you from solving the problem.

**Over the past week, or last 7 days, how many days have you done problem solving for everyday and/or challenging decisions?**

- 0    1    2    3    4    5

**How important is being able to problem solve when being faced with everyday and/or challenging decisions, where 0 is not important at all and 5 is very important?**

- 0    1    2    3    4    5

**How sure are you that you can problem solve when faced with everyday and/or challenging decisions, where 0 is not sure at all and 5 is very sure?**

- 0    1    2    3    4    5

**When you are sick or can't eat your usual foods how often do you do the following? (check all that apply)**

- Replace usual food with carbohydrates or sugar     Drink more water     Take diabetes medication  
 Check ketone level     Check blood sugar more often     Contact health care provider     Do nothing  
 Other



## Healthy Coping

Healthy coping is having ways to help yourself or knowing when and how to seek help when you are overwhelmed by your diabetes. Every person with diabetes has to deal with stress, strong emotions or family situations that can make it hard to manage their diabetes. How you feel and your quality of life can be affected by emotional and social problems.

**Over the past week, or last 7 days, how many days were you able to cope in a healthy way when you faced stress, emotional or family problems?**

0      1      2      3      4      5

**How important is it to you to either help yourself or know when and how to seek help when you are faced with stress, emotional or family problems, where 0 is not important at all and 5 is very important?**

0      1      2      3      4      5

**How sure are you that you can help yourself or know when and how to seek help when faced with stress, emotional or family problems, where 0 is not sure at all and 5 is very sure?**

0      1      2      3      4      5

**How often do you feel depressed?**

a lot       some       a little       not at all

**How much does your diabetes interfere with sexual function?**

a lot       some       a little       not at all

## Goal Setting

**Having diabetes means you may need to make changes. What changes, if any, would you like to make now?**

Activity Eating     Medication taking Monitoring     Problem solving for blood sugars and sick days  
 Reducing risks of diabetes complications     Living with diabetes     None of the above

## Culture

**Do you have any cultural factors that may make it more difficult for you to control your diabetes?**

Yes     No

If yes, please state what these are: \_\_\_\_\_

**Do you have trouble paying for your medications or doctor visits?**

Yes     No

If yes, please explain what kind of trouble: \_\_\_\_\_

**Do you have a support person at home?**     Yes     No