**Winter Haven Hospital Diabetes Self Management Program**
**Adult Diabetes Education Assessment Record**

Date: ______________

Name: ____________________________ Date of Birth: ______________ Age: _____

Address: __________________________ **Email address**: ________________________

City: ______________________ Phone: H_____________________________

State: _____________________ W_____________________________

Zip: ______________________ Other__________________________

Physician Name__________________ Physician Address_________________________

**Statistical Data**: **Sex:** M____ F____

**Ethnic Group** (check all that apply):

African American ___ Asian/Pacific Islander ___

Hispanic/Latino ___ Caucasian ___

Native American ___ Other Group (specify) _____________

**Marital status:** Single_____ Married/Partnered _____ Divorced _____Widowed _____

**Highest grade completed:** _________ **Living alone ____ or with others _____**

**The ways you learn best:**

Discussion____

Reading ____

Lecture____

Video/TV/Computer____

Hands On ____

**Problems with reading/learning?** Y____ N____

If yes, what are they? ___________________

_______________________________________

**Barriers/Difficulties**: Complete only what applies

Visual______________________________________

Hearing_____________________________________

Other_______________________________________

**Your Diabetes Is:**

Type 1____

Type 2 ____

Gestational _____

Other ____

I don't know _____

Date of Diagnosis: _________

Age at Diagnosis: _________

**Were you taught to take care of diabetes?**

Yes: ____ No: ____

If yes, when?______________________________

By whom? _______________________________

**Do you have family with diabetes?**

Yes: ____ No: ____

If yes, who? ______________________________

What type? ______________________________

**Management of Diabetes**: How do you take care of your diabetes?

Diet/exercise: ______ Pills: ______ Insulin: ______ Other injection: ________

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**Nutrition:**

Do you have a current food plan/diet? Y ____ N ____ # of calories: _________________

Type of plan: ____________________Who does the cooking in your home? ___________

How is the food prepared?

Baked ______ Boiled _____ Raw_____ Broiled _____ Fried _____ Other_____________

Weight change in the past year? Y ___N ____ If yes, Lost ____ lbs Gained ____ lbs;

In what period of time? __________________ Reason?_____________________________

What do you drink when you are thirsty? _________________________________________

How many meals or snacks do you eat a day? Meals ____ Snacks ____

At what time are your meals? _______________ At what time are your snacks? _______

How many times a week do you eat out? _______ Type of restaurant: ________________

Other meal/snack times:__________________________________________

What are your biggest challenges to healthy eating?________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Exercise and Physical Activity:**

Do you exercise? Y ____ N ____ Regularly? Y______ N______

If yes, what type(s)?___________________________________________________________

How many times a week?____________ How many minutes each time? _____________

Do you exercise alone or with someone? _______________________________________

Do you have any problems with exercising or has your doctor or provider/nurse practitioner advised you to limit your activities/exercise in any way? Y______ N_______

If yes, please explain:___________________________________________________________

_____________________________________________________________________________

**Home Diabetes Testing**:

Do you test your blood glucose (sugar)? Y___ N____ Name of the meter ____________

How often? _________ Time of tests: _____________ Do you keep a record? Y___ N__

Average results _________________________________________________________________

Do you have a target blood glucose range?_________________________________________

How do you dispose of used lancets (fingerstick needles)? _________________________

Do you ever have high blood glucose (high sugar)?

Yes: ____ No: ____If yes, when/how do you take care of it? _______________________

Why does this happen?_____________________________________________________

Do you test your urine for ketones? Yes: _____ No: ______

If yes, did you have ketones? _______ or ketoacidosis? _________________________

If yes, how was it treated? __________________________________________________

Do you ever have low blood glucose (low sugar)?

Yes: ____ No: ____ If yes, when/how do you take care of it?_______________________

Why does this happen?_____________________________________________________



**LABEL**

**Medicines for Diabetes** (pills)

Name | Dose | Time Taken

______________________ ______________ ________________
______________________ ______________ ________________
______________________ ______________ ________________

**Medicines for Diabetes** (insulin or other injection)

Name ____________ Amount _____________ When taken ___________________
Name ____________ Amount______________ When taken ___________________
Who prepares the injections and gives the medicine? _______________________
Where do you inject? ____________________________________________________
How do you store the medicine? ________________________________________
How do you take your medicine? Using vial and syringes ____ Pen ____ Pump ____
Reuse syringes Y____ N _____ How do you dispose of syringes? ______________

**Medicine for other conditions, prescription, over the counter and supplements: Attach separate page, if needed.**

Name______________ Dosage______________ When taken____________
Name______________ Dosage______________ When taken____________
Name______________ Dosage______________ When taken____________

**General Health:** Food and Medication Allergies: _______________________________

**Do you have any of these health problems (check all that apply)? Please give details.**

High blood pressure _____ If yes, what is your average BP? ______________________
Heart disease _____ If yes, explain:____________________________________________
High cholesterol _____ If yes, explain:_________________________________________
Thyroid disease _____ If yes, explain:_________________________________________
Kidney/bladder problems _____ If yes, explain:__________________________________
Eye/vision problems _____ If yes, explain:_____________________________________
Foot problems _____ If yes, explain:__________________________________________
Numbness/pain _____ If yes, explain, including location:__________________________
Balance problems _____ If yes, explain: _______________________________________
Frequent Infections _____ If yes, what kind? ___________________________________
Sexual function problems _____ If yes, explain: _________________________________
Other medical problems _____ If yes, explain:___________________________________
Last flu shot: _____Last pneumonia vaccine: ______ Last foot exam/Results__________
Last dilated eye exam/Results ____________ Last dental exam/Results ______________

**Hospitalizations (in the past year or related to diabetes), including dates/reasons**

__________________________________________________________________________

Alcohol: Y____ N _____ Drinks per week: _______________________________________
Tobacco: Y ___ N___ Type: _________ # per day: ______ When started ____________
Recreational Drugs: Y ____ N ____ Explain: _____________________________________
Do you wear medical ID? Y _____ N _____

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**How do you rate your health?** 1 Poor 2 Fair 3 Good 4 Very Good 5 Excellent

**Diabetes Health Beliefs: Please answer each of the following**:

I find it hard to believe that I really have diabetes Y ____ N ____

Paying for diabetes care is a problem Y ____ N ____

I have difficulty managing my diabetes Y ____ N ____

I feel unhappy/depressed because I have diabetes Y ____ N ____

All things considered I feel satisfied with my life Y ____ N ____

Does your culture influence your decisions about diabetes (e.g. special foods/fasting or religious observances)? Y ___ N ___ If yes, how ______________________________

Who is your support person(s)? _____________ Who will attend class? _____________

How do you rate the level of stress/tension in your life?

**1 Very Low** **2 Low** **3 Moderate** **4 High** **5 Very High**

What are your stressors? ____________________________________________________

______________________________________________________________________

What questions do you have about diabetes? ____________________________________

______________________________________________________________________

______________________________________________________________________

What are your goals for attending these education sessions? _______________________

______________________________________________________________________

______________________________________________________________________

**Participant Signature** ______________________________ **Date**: ____________

**Educator Signature** ________________________________ **Date**: ____________

Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______

Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______

Date______Ht: _____ Wt: _____ BMI: _____ BP: ______ A1c: ______ BG: ______

Lab data by history:

Fasting blood glucose ________ HbA1c ________ Urine microalbumin ___________

Total Cholesterol ___________ HDL______ LDL_______ Triglycerides___________

**LABEL**

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