North Atlanta Endocrinology & Diabetes, P.C.

Diabetes Self-Management Education

ASSESSMENT FORM

Name: ____ Date: ____________________

Date of Birth: ________/________/________ Gender: F_____ M _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Ethnic Background: White/Caucasian _____ Black/ African American _____ Hispanic _____
Native American _____ Middle Eastern _____ Other: ________________

What is your language preference? English _____ Other: ________________

What is the last grade of school completed? Grade school _____ High school _____ College _____

Email address: ________________________________ (For diabetes education/follow-up ONLY)

1. What type of diabetes do you have? Type I _____ Type 2 _____ Gestational _____
   Pre-Diabetes _____ Do not know _____
2. When were you diagnosed with diabetes? _______________
   List of relatives with diabetes____
3. Do you take diabetes medications? Yes _____ No _____ (If yes check all that apply below)
   Diabetes pills _____ Insulin injections _____ Byetta injections _____ Victoza injections _____
   Symlin injections _____ Combination of pills and injections _____
4. Do you have: High blood pressure _____ High cholesterol _____ Nerve damage _____
   Kidney disease _____ Heart disease _____ Lung disease _____ Eye disease _____
   Depression _____
5. Have you attended a diabetes education program in the past? Yes _____ No _____
   How long ago? _______________
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? Yes _____ No _____
   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? Yes _____ No _____
   Do you have any dietary restrictions: Salt _____ Fat _____ Fluid _____ Other: ______________
   None _____
   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? Yes _____ No _____
   Cook your own meals? Yes _____ No _____
   How often do you eat out? ____
10. Do you drink alcohol? Yes _____ No _____ Occasionally _____ How many drinks per week _____

11. Do you use tobacco? Yes _____ No _____ Quit: _____
12. Do you exercise? Yes _____ No _____ Type ________________________ How often ____________
13. Do you check your blood sugars? Yes _____ No _____ How often? Once a day _____
    2 or more/day _____ 1 or more/week _____ Occasionally _____
    What is your blood sugar range: Before meals: _____ to _____ After Meals: _____ to _____
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? Yes _____ No _____
16. In the past 12 months which of these test/procedures you have had: Dilated eye exam _____
    Urine test for protein _____ Foot exam _____ Dental exam _____ Blood Pressure _____
    Weight _____ Cholesterol _____ HgA1c _____ Flu Shot _____ Pneumonia Shot _____

17. In your own words, what is diabetes? ____
18. How do you learn best? Listening _____ Reading _____ Observing _____ Doing _____
19. Do you have any difficulty with? Hearing _____ Seeing _____ Reading _____ Speaking _____

20. Do you have any cultural or religious practices or beliefs that influence how you care for you
    diabetes? Yes _____ No _____ Please describe: ____
21. Do you feel good about your general health? Yes _____ No _____ Not sure _____
    Does diabetes interfere with other aspects of your life? Yes _____ No _____
    How is your level of stress? High _____ Low _____ No stress _____
22. How do you handle stress? ____
    Do you struggle with making changes in your life to care for your diabetes: Yes _____ No _____
23. What concerns you most about your diabetes? ____
24. What is hardest for you in caring for you diabetes? ____________________________________
25. What are you most interested in learning from your diabetes education sessions? ____________
    ____

For Women Only

2. Pregnancy and Fertility:
   Are you: Pre-menopausal _____ Menopausal _____ Post-Menopausal _____ N/A _____
   Are you pregnant? Y _____ N _____ When are you expecting? ______________________________
   Are you planning on becoming pregnant? Y _____ N _____
   Are you aware of the impact of diabetes on pregnancy? Y _____ N _____
   Are you using birth control? Y _____ N _____ N/A _____

Please do not write below this line

Clinician Assessment Summary:

Education Needs/education plan for patient:

Diabetes Disease Process
Using Medications
Psychosocial Adjustment
Nutritional Management
Physical Activity
Preventing Acute Complications
Preventing Chronic Complications
Behavior Change Strategies
Risk Reduction Strategies
Monitoring

Date: ______________________ Clinician Signature: ____