DIABETES ASSESSMENT FORM

Name ___________________________________ Date________________________

Being a person with diabetes means ____________________________________________

____________________________________________________________________________

When I think about having diabetes, I feel __________________________________________

____________________________________________________________________________

How do I feel about giving up old habits and starting new ones in order to improve my health? __________________________________________

____________________________________________________________________________

Do I believe it simply doesn’t matter if I change my habits? ___________________________

Do I lack self-confidence in my ability to make changes? ____________________________

GETTING READY

What can I do to make a difference in my physical and emotional health? ________________

____________________________________________________________________________

Is there anything I should do to prepare myself for these changes? __________________________

____________________________________________________________________________

Who is available to help me? ______________________________________________________

What can they do to help me? _____________________________________________________

DIET

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do? Please check all that apply:

☐ Follow a low-fat eating plan.
☐ Reduce the number of calories you eat.
☐ Eat 5 servings per day of fruits and vegetables.
☐ Eat very few sweets.
☐ Other (specify): ___________________________________________________________________

☐ You have not been given any advice about your diet.

How often did you follow your recommended diet since your last visit?  ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

PHYSICAL ACTIVITY

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do? Please check all that apply:

☐ Do low to moderate activity (such as walking) on a daily basis.
☐ Exercise continuously for at least 20 minutes at least 3 times a week.
☐ Fit physical activity into your daily routine (take stairs instead of elevators, park a block away and walk).
☐ Other (specify): ___________________________________________________________________

☐ You have not been given advice about physical activity.

How often did you follow your exercise recommendations since your last visit?  ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Continued  ➤

DIABETES ASSESSMENT FORM

SELF-MONITORING OF BLOOD GLUCOSE

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do? Please check all that apply:
- Test your blood glucose (sugar) using a drop of blood from your finger.
- Test your blood glucose using a machine to read the results.
- Test your urine for sugar.
- Other (specify):___________________________________________________________________
- You have not been given advice about testing your blood glucose.

How often did you follow your blood glucose testing recommendations since your last visit? ○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

DIABETES MEDICATION

Which of the following medications for your diabetes has your doctor prescribed? Please check all that apply:
- An insulin shot 1 or 2 times a day.
- An insulin shot 3 or more times a day.
- Diabetes pills to control your blood glucose level.
- Glucophage (Metformin tablets).
- Other (specify):___________________________________________________________________
- You have not been prescribed medication for your diabetes.

How often did you take your diabetes medication since your last visit? ○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

FOOT CARE

Which of the following has your health care team (doctor, nurse, dietician or diabetes educator) advised you to do? Please check all that apply:
- Check your feet daily for sores cuts, calluses, infection, etc.
- Check inside your shoes daily for loose objects or rough edges.
- Not to go barefoot either inside or outdoors.
- Wash your feet daily, remembering to dry between your toes.
- Other (specify):___________________________________________________________________
- You have not been given advice about foot care.

How often did you follow your foot care recommendations since your last visit? ○ Always ○ Usually ○ Sometimes ○ Rarely ○ Never

SMOKING

Have you smoked, even a puff, during the last 7 days? ○ Yes ○ No (skip to next section)
Has anyone from your health care team advised you to stop smoking? ○ Yes ○ No
Are you seriously considering stopping smoking in the near future? ○ Yes ○ No

MANAGING SYMPTOMS

Has your health care team instructed you what to do if your blood glucose is too low or too high? ○ Yes ○ No

How confident are you that you know what to do if your blood glucose is too low?
Not confident 1 2 3 4 5 6 7
How confident are you that you know what to do if your blood glucose is too high?
Not confident 1 2 3 4 5 6 7

Thank you for taking the time to fill out this form.