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 ➤

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

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 I 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 **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 **Confident**

1 2 3 4 5 6 7

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