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 or 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

**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 | 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!*