THE POLYCLINIC

Diabetes Self-Management Education Initial Assessment

Please answer the following questions to the best of your ability.

Name: _____

Date of birth: _____

Today's date: _____

What year were you diagnosed with diabetes?

Have you had Diabetes education? If so, when?

Education (check one of the following):

- ☐ Elementary School
- ☐ Some High School
- ☐ High School Degree (or GED)
- ☐ Some College
- ☐ College Degree
- ☐ Post Graduate Degree

Occupation (check one of the following):

- ☐ Requires I sit the majority of my day (desk job)
- ☐ Sit most of the day but get up about every 30 minutes
- ☐ Frequent activity/movement (manual labor)
- ☐ Unemployed (including retired or disabled)

Medical History:

Do you have difficulty with (check all that apply):

- ☐ Hearing
- ☐ Seeing
- ☐ Reading
- ☐ Speaking
- ☐ Problems with use of hand
- ☐ Problems with use of feet

How often do you need to have someone help you when you read instructions or pamphlets from your doctor or pharmacy?

- ☐ Never
- ☐ Sometimes
- ☐ Rarely
- ☐ Always

Do you have trouble paying for your medications or doctors' visits? (If yes, please explain)

Yes or No

Number of emergency room visits or 911 calls related to your diabetes and requiring assistance within the last three months: _____

Number of hospital admissions for diabetes within the last three months: _____

Number of days missed from work, school or your usual routine because of your diabetes within the last three months: _____

Do you use recreational drugs? (Circle one)

Yes or No

Reducing Risk:

When did you last see the eye doctor? _____

When did you last see the Dentist? _____

When did you last have a pneumonia vaccine? _____

When did you last have your feet checked by a health care provider? _____

In the past year have you?

☐ Lost more than 10 lbs ☐ Gained more than 10 lbs ☐ Stayed the same

Have you had any symptoms of diabetes over the past 4 weeks? (Circle all that apply)

None	Fatigue
Excessive Thirst	Nausea/Vomiting
Frequent Urination	Leg cramps
Weight changes	Blurred Vision
Numbness of hands or feet	

Physical Activity:

During the past week/7 days, how many days were you able to be active?

0 1 2 3 4 5 6 7

Have you ever been advised by a doctor to limit your exercise in any way? Yes or No

Healthy Eating:

During the past week/7 days, how many days were you able to follow a healthy eating plan?

0 1 2 3 4 5 6 7

How many times in the past week did you eat out?

Please complete a 24-hour recall of your diet. Is this a typical day for you or abnormal? (Use back of page if needed)

Breakfast –
Snack –
Lunch –
Snack –
Dinner –
Snack –

Taking Medication (leave blank if not currently taking any Diabetes medications)

How many times over the past week/7 days have you missed taking your diabetes medicines as prescribed?

Why have you missed taking your diabetes medication?

Monitoring – Review meter readings if applicable

Healthy Coping

Describe some coping strategies you use to handle stress.

Do you have a support person at home or a close relative/friend who helps support your diabetes diagnosis? (Circle one)

Yes or No

How often do you feel stressed, depressed or anxious?

☐ All of the time ☐ Most of the time

☐ Occasionally ☐ Rarely/Never

Culture

Do you have any specific restrictions regarding eating, taking medications or checking your blood sugars related to religious, cultural or dietary reasons? (If yes, please explain)

Yes or No

What are your main concerns related to managing your diabetes? What would you like to learn during this class? (Circle all that apply)

Disease Process	Chronic Complications
Meal Planning	Acute Complications
Eating Out	Foot and Skin Care
Physical activity/Exercise	Dealing with Stress and Diabetes
Medication Options	Other Psychosocial Issues
Blood Sugar Monitoring	Dealing with High or Low Blood Sugars
Managing Diabetes When You Are Sick	Other:

If you are new to The Polyclinic please answer the following questions:

Tobacco Use (circle one):

Yes Never Quit

Alcohol Use (circle one):

Yes No

_____ Glasses of wine per week

_____ Beers per week

_____ Shots of liquor per week

When was the last time you had a Hemoglobin A1c checked?

Result: _____

When was the last time you had your cholesterol levels checked?

Results: _____

Have you ever been diagnosed with any of the following? (Check all that apply)

Diagnosis	
Diabetes	
High Blood Pressure	
High Cholesterol	
Kidney Disease	
Heart Disease	
Thyroid Disease	
Dental Problems	
Asthma	
Liver Disease	
Stroke	
Depression/Anxiety	
Shortness of Breath	
Numbness/Tingling in Limbs	
Stomach/Bowel Problems	
Headaches/Migraines	
Anemia	
Arthritis	
Cancer	
Gout	