Diabetes Center Health Questionnaire

1. Name:_______________________________________Date:________Age:_______Race:______Sex:_____
2. Height:__________Present weight:_________Usual weight:________Desired weight:________
3. What is your preferred way of receiving future diabetes update class reminders?
   Regular mail____ Email____ Email address:____

DIABETES HISTORY

1. How long have you had diabetes?____
2. Have you had diabetes education before? Yes____No____When/where__________________________
3. What is diabetes?____ Don't know ___
4. What type of diabetes do you have? Type 1___Type 2 ___Pre-diabetes___Gestational___Don't know ___

MONITORING

1. Do you have a meter to check your blood sugars? Yes____ No____ Type meter:__________________
   How often do you check your sugar? ______________________Usual blood sugar range:_____to_____
   What is your target blood sugar range?______________________________ Don't know ___
2. What was the result/date of your last A1c?________________________________ Don't know ___

MEDICAL HISTORY: Please check all these that you have:

_____high blood pressure
_____stroke
_____heart disease
_____chest pain
_____heart surgery (date_____)
_____shortness of breath
_____high cholesterol (level______)
_____chronic lung problems
_____other:___________________________
_____asthma
_____thyroid disease
_____kidney/bladder problems
_____numbness/pain/tingling in hands or feet
_____other foot problems
_____cancer
_____depression or anxiety
_____surgeries in the past 5 years:___________________________
_____frequent nausea, vomiting, constipation, or diarrhea
_____problems with sexual functioning
_____eye or vision problems
_____hearing problems

1. Food or drug allergies:____
2. Have you had an EKG or stress test lately? Yes____ No____ Date_________Results_________________
3. Do you use tobacco: cigarette____pipe___cigar___chewing___none____quit____How long ago:________
4. Do you drink alcohol? Yes___No___ Type:_________________How many_____Per day____
   Per week____Occasionally___
5. Do you closely examine your feet daily? Yes____ No____

MEDICATIONS: Please list medications that you take. Include dosages and what time you take them:

Name of Medication Dosage Time

____
____
____
____
____
____

Do you have problems affording your medications? Yes____ No____
How often do you miss a dose of medicine? Daily___Several times a week___Few times a month___
Once in a while___Never___

ACTIVITY

1. Do you exercise regularly? Yes____ No____ How many days per week? 0 1 2 3 4 5 6 7
2. Type of exercise: _________________________________How long do you usually exercise? ___________
3. What are some things that keep you from being active?____

Staff use: MD exercise clearance
Yes No

GENERAL INFORMATION

1. Marital Status: Single____ Married____ Divorced____ Widowed____
2. How many people live in your household?____
3. Are you currently employed? Yes___ No___ Occupation:___________________Work hours:_______
4. Last grade of school completed?____

NUTRITION

1. How often do you miss a meal? Daily___Several times a week___Few times a month___ Once in a while___Never___
2. How often do you overeat? Always____ Most of the time____About half the time____ Occasionally____ Never_____
3. Do you have any diet restrictions: Salt____Fat____Fluid____None____Other________________________
4. Give a sample of food you usually eat in a typical day:
   Time:_______Breakfast:____
   Time:_______Snack:____
   Time:_______Lunch:____
   Time:_______Snack:____
   Time:_______Dinner:____
   Time:_______Snack:____

HIGH AND LOW BLOOD SUGARS

1.. Low blood sugar:
   * How often do you have low blood sugar? Never____ One or more per week____ Once per month___
   * How do you treat your low blood sugar? ____
2. High blood sugar:
   * Can you tell when your blood sugar is too high? Yes____ No____
   * What do you do when your sugar is high? ____
3. Check any of the following tests/procedures you have had in the last 12 months:
   Dilated eye exam____ urine test for protein____ dental exam____ flu shot____ pneumonia shot____

CONCERNS

1. Do you have any cultural or religious practices or beliefs that would influence how you care for your diabetes? Yes____ No____ Please describe:____
2. Do you have a lot of stress? Yes____ No____ What are some things you do to cope with stress?
   ____
3. How do you feel about having diabetes? ____
4. From whom do you get support for your diabetes? Family___Co-Workers___Healthcare Providers____ No one___
5. I am confident that I can do what is necessary to keep diabetes under control: very confident____ somewhat confident_____don't know yet____ not very confident____ not confident at all_____
6. What concerns you most about your diabetes? ____
7. Having diabetes means that you might need to make some changes. What changes, if any, would you like to make now? ____
8. What are some things that might keep you from making the changes that you want? _______________
   ____

PERSONAL

1. A personal health goal of mine is:____
2. In what area would you especially like to get help with today? _________________________________

WOMEN ONLY: PREGNANCY AND FERTILITY

1. Are you pregnant? Yes____No___
2. If yes, what is your expected delivery date?___________________ Pre-pregnancy weight:___________
   How many live births have you had?_______Birthweights:_____________________________________
   Did you have diabetes prior to this pregnancy?____

____

Diabetes Educator/Date