UP HEALTH SYSTEM
MARQUETTE
A Duke LifePoint Hospital

Nutrition & Wellness/Diabetes Education Department
MGH Site:(906) 225-3221. ESC Site: (906) 789-5978

Diabetes Self-Management Training Self-Assessment

General Information: ***Date:*** ________________

Name: ____ Birthdate: _____________________

Email address: ____

How did you hear about this program: ____

Check your racial/ethnic group: ☐ White/Caucasian ☐ American Indian or Alaskan Native
☐ African American/Black ☐ Asian /Pacific Islander ☐ Hispanic/Latino/Mexican ☐ Other

Social: Do you work: ☐ Yes ☐ No ☐ Retired ☐ Disabled ☐ Student

Type of job and work hours: ____

How far did you go in school: ________________ What language do you use at home: ________________

How do you learn best (check all that apply): ☐ Reading ☐ Seeing/visual ☐ Computer ☐ Listening ☐ Doing ☐ Group discussion ☐ Watching videos/TV ☐ Other ________________________________

Does your insurance cover all or part of (check all that apply): ☐ Doctor visits ☐ Diabetes Education
☐ Blood sugar meter(s) ☐ Blood sugar meter supplies (test strips, lancets, other) ☐ Medications

If you have no insurance, can you pay for these things: ☐ Yes ☐ No

Medical History: Have you ever or do you now have any of the following:

☐ High blood pressure ☐ High cholesterol ☐ Mental health problems ☐ Heart disease
☐ High triglycerides ☐ Amputation ☐ Depression ☐ Thyroid disease
☐ Kidney disease ☐ Poor leg circulation ☐ Pain or fatigue syndromes ☐ Eye disease
☐ Dental disease ☐ Allergies (include food) ________________________ ☐ Stroke
☐ Sexual problems ☐ Stomach or bowel problems ☐ Arthritis
☐ Frequent infections ☐ Skin problems (type) __________________________ ☐ Osteoporosis
☐ Other ____

Have you ever had a pneumonia shot: ☐ No ☐ Yes – date: ___________________________

Do you get flu shots: ☐ No ☐ Yes – date of last flu shot: _____________________________

Do you drink alcohol: ☐ No ☐ Yes – how much: ☐ Daily ☐ 2-3 drinks/week ☐ 1 drink/week ☐ Other

Do you smoke: ☐ No ☐ Past ☐ Yes – would you like info about quitting: ☐ No ☐ Yes

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Please list **ALL** medications and supplements:

Name	Amount	What is it for?

Continue on the back if more space is needed

If on insulin, method of administration: ☐ Pen ☐ Pump ☐ Syringe

Date insulin started: ___________________ Do you have a prescription for glucagon: ☐ Yes ☐ No

Nutrition:

Height: __________ Weight: __________ Is your current weight comfortable: ☐ Yes ☐ No

Have you ever seen a dietitian (RD) for diabetes: ☐ No ☐ Yes – when: ______________________________

How many meals do you eat every day: ________________ How many snacks daily: ________________

How often do you eat out or bring home 'take out': ____

Where: ____

Diabetes History:

What type of diabetes do you have: ☐ Type 1 ☐ Type 2 ☐ Not sure For how long: ____________

Have you had diabetes education in the past: ☐ No ☐ Yes – check box below and write date and place

☐ Self-taught (explain how): _________________________________ ☐ Doctor's office: _________________

☐ Group classes: _____________________ ☐ One-on-one meeting/s with diabetes educator: ___________

Do you check your blood sugar: ☐ No ☐ Yes – how often: ____

Have you ever had a low blood sugar: ☐ No ☐ Yes – how often: ___________________________________

How did you feel: ________________________________ What did you do: ____________________________

Have you ever had a high blood sugar: ☐ No ☐ Yes – how often: __________________________________

How did you feel: ________________________________ What did you do: ____________________________

Do you know what your results were for any of the following lab tests:

Test	Result	Date
Total Cholesterol		
LDL		
HDL		
Triglycerides		
Hemoglobin A1c		

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Have you ever had a dilated eye exam: ☐ No ☐ Yes – date: ______________________________________

Do you do a self foot exam: ☐ No ☐ Yes – how often: ☐ Daily ☐ Weekly ☐ Monthly

Have you ever had a foot exam by a doctor: ☐ No ☐ Yes – date: __________________________________

How often do you go to the dentist: __________________ Do you carry diabetes ID: ☐ Yes ☐ No

Activity/Exercise:

How often are you active: ☐ None ☐ 30+ min. 1x/week ☐ 30+ min. 2x/week ☐ 30+ min. 3x/week ☐ 30+ min. 4x/week ☐ daily

Are you as active as you think you should be: ☐ Yes ☐ No – why not: _____________________________

What do you do to be active or to exercise: ____

More About You:

How **interested** are you about learning more about diabetes: 1 2 3 4 5 (Not … Very)
(please circle a number)

How **stressed** are you (please circle a number): 1 2 3 4 5 (Not … Very)

How do you handle things that worry you: ____

How has diabetes affected your life; or if diabetes is new, how do you think diabetes will affect your life: ____

What **will be**, or **is** the hardest part of taking care of your diabetes: ________________________________

Dor Instructional Staff Only:

Education Plan: ☐ Provide individual instruction for specific content area(s):
____

☐ Group classes: ☐ DM 101 ☐ Nutrition ☐ Know your Numbers ☐ Continuing your Journey

☐ Completed

Reviewed by: ____ Date: _____

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