Geckle Diabetes and Nutrition Center
6535 N. Charles St., Suite 405
Baltimore, MD 21204
P: 443-849-2036 F: 443-849-8999

# PARTICIPANT SELF ASSESSMENT OF DIABETES MANAGEMENT

Name: _____ Date: _____

Date of Birth: _____

1. What type of diabetes do you have? ❑Type 1 ❑Type 2 ❑Pre-Diabetes ❑Gestational(GDM) ❑Don't Know
2. Year/Age of Diabetes Diagnoses: _____/_____ List relatives with diabetes: _____
3. What is the last grade of school you have completed? _____
4. Are you currently employed? ❑ Y ❑ N What is your occupation? _____
5. How many people live in your household? _____
6. How are they related to you? _____
7. From whom do you get support for your diabetes? ❑Family ❑Co-workers ❑Healthcare providers ❑Support group ❑No-one
8. Do you have a meal plan for dIabetes? ❑Y ❑N If yes, please describe: _____

About how often do you use this meal plan? ❑Never ❑Seldom ❑Sometimes ❑ Usually ❑ Always

Do you read and use food labels as a dietary guide? ❑Y ❑N

Do you have any diet restrictions: ❑Salt ❑Fat ❑Fluid ❑None ❑Other _____

Give a sample of your meals for a typical day:

Time: _____ Breakfast: _____

Time: _____ Lunch: _____

Time: _____ Dinner: _____

Time: _____ Snack: _____

9. Do you: do your own food shopping? ❑Y ❑N Cook your own meals? ❑Y ❑ N
   How often do you eat out? _____
10. Do you drink alcohol? ❑ Y ❑ N Type: _____ How many: _____ ❑per day ❑ per week ❑ occasionally
11. Do you use tobacco? ❑ cigarette ❑pipe ❑cigar ❑chewing ❑none ❑quit _____how long ago
12. Do you exercise regularly? ❑Y ❑N Type: _____ How often: _____
13. My exercise routine is: ❑ Easy ❑Moderately Intense ❑ Very Intense
14. Do you check your blood sugars? ❑Y ❑N
    Blood Sugar range: _____ to _____
    How often: ❑ Once a day ❑ 2 or more/day ❑ 1 or more/Week ❑Occasionally
    When: ❑ Before breakfast ❑ 2 hours after meals ❑ Before bedtime
15. In the last month, how often have you had a low blood sugar reaction: ❑ Never ❑ Once ❑ One or more times/week
    What are your symptoms? _____
16. Can you tell when your blood sugar is too high? ❑ Y ❑ N
    What do you do when your sugar is high? _____
17. Check any of the following test/procedures you have had in the last 12 months:

❑ dilated eye exam ❑ urine test for protein ❑ foot exam ❑healthcare professional ❑ dental exam ❑ blood pressure ❑ weight ❑ cholesterol ❑ HgA1c ❑ flu shot ❑pneumonia shot

17. In the last 12 months, have you: ❑ used the emergency room service ❑ been admitted to a hospital
    Did the ER visit, or hospital admission diabetes related? ❑ Y ❑ N
18. Do you have any of the following problems? ❑ eye problems ❑ kidney problems ❑dental problems ❑depression

**Provider Reviewing this form with Patient:** _____

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❑ numbness/tingling/loss of feeling in your feet ❑high blood pressure ❑ high cholesterol ❑sexual problems

❑ 18b. Are you having pain today? ❑ Y ❑ N; Location of pain _____; Severity 1-10 _____.

Is this pain chronic? ❑ Y ❑ N; If yes, who is the physician managing your pain? _____

19. Have you had previous instruction on how to take care of your diabetes? ❑ Y ❑ N How long ago? _____

20. How do you learn best: ❑Listening ❑Reading ❑Observing ❑Doing?

Do you have any cultural or religious practices or beliefs that influence how you care for your diabetes? ❑ Y ❑ N

Please describe: _____

22. Do you use computers: ❑ to email ❑ look for health and other information?

23. Pregnancy and Fertility: **(Men please skip to #25)**

Last menstrual period? _____

Are you pregnant? ❑ Y When are you expecting? _____ ❑ N

Are you planning on becoming pregnant? _____

Have you been pregnant before? ❑ Y ❑ N Do you have any children? ❑ Y Ages_____ ❑ N

Are you aware of the impact of diabetes on pregnancy? ❑ Y ❑ N

Are you using birth control? ❑ Y please specify _____ ❑ N

24. Please state whether you agree, are neutral or disagree with the following statements:

I feel good about my general health: ❑ agree ❑ neutral ❑ disagree

My diabetes interferes with other aspects of my life: ❑ agree ❑ neutral ❑ disagree

My level of stress is high: ❑ agree ❑ neutral ❑ disagree

I have some control over whether I get diabetes complications or not: ❑ agree ❑ neutral ❑ Disagree

I struggle with making changes in my life to care for my diabetes: ❑ agree ❑ neutral ❑ disagree

26. During the past month:

1. Have you often been bothered by feeling down, depressed, or hopeless? ❑ Yes ❑ No
2. Have you been bothered by little interest or pleasure in doing things? ❑ Yes ❑ No
3. Are you involved in therapy with a counselor or psychologist? ❑ Yes ❑ No

27. How do you handle stress? _____

28. What are your thoughts or concerns about diabetes? _____

29. What are you most interested in learning from these diabetes education sessions? _____

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**MEDICATIONS: (Please complete if you have NOT been a patient at GBMC in the past 6 months or if you have entered your current medications into the patient portal**

**Medication allergies and reactions (please list):** _____

**CURRENT MEDICATIONS** (include over-the-counter and supplements)

| MEDICATION NAME | DOSE/FREQUENCY | REASON |
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**Provider Reviewing this form with Patient:** _____ 