Natividad
Inspiring healthy lives℠

Diabetes Education Center
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Diabetes Self-Management Questionnaire

General Information

1. Name:_____ Age:_____
2. Address:_____ City:_____ Zip Code:_____
3. Home phone:_____ Work phone:_____ Cell:_____
4. Your primary physician's name:_____
5. Your diabetes physician's name:_____
6. What is your race or ethnic background?
   - ❑ American Indian or Alaskan Native
   - ❑ Asian/Chinese/Japanese/Korean
   - ❑ Black/African American
   - ❑ Hispanic/Latino/Mexican
   - ❑ Native Hawaiian or other Pacific Islander
   - ❑ White/Caucasian
   - ❑ Other:_____

Socioeconomic / Support System

1. Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
2. How many people live in your household?_____
3. Does anyone else who lives with you have diabetes? ❑ No ❑ Yes: Who?_____

Is there anyone who will help you with your diabetes care? ❑ No ❑ Yes

If "yes," who?_____

If different, who is your primary support person/caregiver? ❑ None ❑ Yes

If "yes," who?_____

4. Occupation:_____ Work hours:_____
5. Last grade of school completed:_____
6. Any religion preference?_____

Cultural Influences

1. Do you have any special dietary needs, religious and/or cultural observances? ❑ Yes ❑ No

   If "yes," explain:_____
2. What is your language preference? Spoken:_____ Reading:_____

Diabetes History

1. How long have you had diabetes or year diagnosed?_____
2. What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Don't know

Chronic Complications - Are you aware of or have you ever been told by a doctor you have any of these problems? *Please rate as: L=Little M=Moderate S=Severe*

❑ Eye problems, explain:_____

❑ Heart/artery problems, explain:_____

❑ Nerve problems, explain:_____

❑ Teeth/gums problems, explain:_____

❑ Feet/leg problems, explain:_____

❑ Skin problems, explain:_____

❑ Gastrointestinal problems, explain:_____ Bowel Movements per day:____

❑ Sexual problems, explain:_____

❑ Kidney problems, explain:_____

❑ Frequent infections, explain:_____

❑ Other problems, explain:_____

Diabetes Health Attitudes / Learning

1. How would you rate your understanding of diabetes? ❑ Good ❑ Fair ❑ Poor
2. In your own words what is diabetes?_____
3. Have you ever been instructed on diabetes care? ❑ No ❑ Yes: Where and by whom?

   _____
4. Do you have any physical limitations that may affect your ability to perform your self-care?
   ❑ Hearing problems ❑ Problems with the use of your hands
   ❑ Vision loss (not corrected by glasses or contacts) ❑ Problems with the use of your feet
5. How do you learn best?
   ❑ Written materials ❑ Verbal discussions ❑ Video ❑ Hands-on/Doing

   ❑ Other_____
6. Do you have any other barriers to learning (for example, problems with reading, writing, and/or understanding numbers)? ❑ No ❑ Yes: Describe barrier(s):_____

Medical History

1. Have you ever been diagnosed, ever been told, or have you had problems with the following?
   - ❑ High Blood pressure
   - ❑ High Cholesterol/Triglycerides
   - ❑ Kidney/Bladder problems
   - ❑ Eye or vision problems
   - ❑ Frequent nausea, vomiting, constipation, diarrhea
   - ❑ Surgery in the last 5 years
   - ❑ Heart disease/Chest pain
   - ❑ Thyroid disease
   - ❑ Asthma
   - ❑ Depression or anxiety
   - ❑ Circulation problems
   - ❑ Obesity
   - ❑ Shortness of Breath
   - ❑ Stroke
   - ❑ Numbness/pain/tingling of hands/feet
   - ❑ Other health problems:_____

2. Do you have any allergies? ❑ No ❑ Yes: Medication/foods:_____

3. Do you smoke? ❑ No ❑ Yes: How much? _____

   Have you ever smoked in the past? ❑ No

   ❑ Yes: How long did you smoke for?_____ How much?_____

   When did you quit?_____

   Have you ever tried to quit? ❑ No ❑ Yes: How long ago?_____

   Would you like information on how to quit? ❑ No ❑ Yes

4. Do you drink alcohol? ❑ No ❑ Yes If "yes," amount and type?_____

Family History

1. List any family members with diabetes:_____

   With high blood pressure:_____

   With heart attacks or other heart problems:_____

   With stroke:_____ With cancer:_____

Health Care Used in Past 12 months

1. When was your last physical examination?_____
2. How often do you see your regular doctor?_____
3. Have you been hospitalized within the last 12 months? ❑ No ❑ Yes

   If "yes," describe reason(s) and where:_____
4. Have you been to the emergency room within the last 12 months? ❑ No ❑ Yes

   If "yes," describe reason(s) and where:_____

Your Diabetes Self Care Behaviors

Healthy Eating

1. Height:_____ Weight:_____ What weight are you comfortable at?_____
2. Has your weight changed in the past three months? ❑ No ❑ Yes If "yes," I've ❑ lost / ❑ gained_____ lbs.

   Was the weight change intentional? ❑ No ❑ Yes:_____
3. Highest Weight/Age:_____ Lowest Weight/Age:_____ Provider/Physician Goal Weight:_____
4. Have you ever received diet counseling? ❑ No ❑ Yes If "yes," describe:_____
5. Do you have a current meal plan?_____ If so, what is it?_____
6. What is your biggest challenge to eating healthily?_____
7. How many times do you eat per day? ❑ Meals:_____ ❑ Snacks:_____
8. Times of meals: am:_____ noon:_____ pm:_____ snacks:_____
9. If you are a minor and/or a student, which meals do you eat at school? _____
10. How often do you eat/drink (answer **per day** or **per week**):

    ❑ Fruit:_____ ❑ Vegetables:_____ How much water per day?_____ ❑ Alcohol:_____

    ❑ Milk:_____ ❑ Fat-free ❑ 1 % ❑ 2 % ❑ Whole ❑ Soy ❑ Almond ❑ Other milks _____

    Beverages with sugar: Juice:_____ Soft drinks:_____ Others:_____

    Sweets/desserts:_____ Sugar-free desserts/drinks:_____

    Starches eaten: State number of servings eaten **meal or per day**

    ❑ Bread:_____ ❑ Cereal:_____ ❑ Beans:_____ ❑ Tortillas:_____ ❑ Rice:_____

    ❑ Pasta:_____ ❑ Corn/Peas:_____ ❑ Potatoes:_____ ❑ Oats:_____ ❑ Other:_____

    Meats/Proteins: State number of times eaten **per week**

    ❑ Chicken:_____ ❑ Red Meats:_____ ❑ Fish:_____ ❑ Turkey:_____

    ❑ Pork:_____ ❑ Eggs:_____ ❑ Cheese:_____ ❑ Nuts/Nut butters:_____

    ❑ Other:_____

    Cooking Oil/Fat used: ❑ Lard/Shortening:_____ ❑ Butter/Margarine:_____ ❑ Olive:_____

    ❑ Vegetable/Corn:_____ ❑ Canola:_____ ❑ Peanut:_____

    ❑ Other:_____
11. Who does the cooking?_____ Who usually does the grocery shopping?_____
12. How many times during the week do you eat away from home?_____
13. How often is your meal away from home: Cafeteria style:_____ Fast food:_____ Buffet:_____

    Sit-down restaurant:_____ Other:_____

14. How is your food usually prepared? ❑ Fried ❑ Baked ❑ Broiled ❑ Grilled ❑ Steamed ❑ Boiled

    ❑ Other forms(s)_____

15. How would you describe your portions? ❑ Small ❑ Average ❑ Large

16. How would you describe your appetite? ❑ Increased ❑ Normal ❑ Decreased

17. List any food allergies or intolerance:_____

    _____

18. Any other special diet needs:_____

    _____

19. How do mood/stress affect your eating?_____

    _____

Food Insecurity

1. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn't enough money for food? ❑ No ❑ Yes

   If yes, how often did this happen? ❑ Almost every month ❑ Some months but not every month ❑ In 1-2 months

2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ❑ No ❑ Yes

3. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food? ❑ No ❑ Yes

4. Answer the following statements regarding your food situation:

   1) "The food that I bought just didn't last, and I didn't have money to get more."

   ❑ Often true ❑ Sometimes true ❑ Never true

   2) "I couldn't afford to eat balanced meals."

   ❑ Often true ❑ Sometimes true ❑ Never true

Being Active

1. Do you exercise regularly? ❑ No ❑ Yes Types of exercise(s):_____

   How many days per week do you exercise:_____ How many minutes do you exercise per day?_____

   What time of day do you exercise?_____

   Note: If you are a minor/student, please include exercise during PE in school.

2. List any problems with exercise:_____

3. How important is it to you to be active, where **0** is not important at all and **10** is very important? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

4. How sure are you that you can be active, where **0** is not sure and **10** is very sure? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

Monitoring

1. Do you test your blood for sugar? ❑ Yes ❑ No

   If "yes," what blood sugar monitor do you use?_____

   Do you have any problems with your monitor? ❑ No ❑ Yes_____

   How often do you test? ❑ Once a day ❑ 2 or more times a day ❑ Once/Twice a week ❑ Rarely/Never

   Usual results? Mornings:_____ Afternoon:_____ Bedtime:_____ After Meals:_____ Other times:_____

2. Do you keep a record? ❑ Yes ❑ No

3. What is considered a normal blood sugar range?_____

4. What are **your** target numbers?_____

5. How often do you have **HIGH** blood sugar? (250 or more) ❑ Daily ❑ Several times a week
   ❑ A few times a month ❑ Once in a while ❑ Rarely or never ❑ Don't know

6. How often do you have **LOW** blood sugar (70 or less)? ❑ Daily ❑ Several times a week
   ❑ A few times a month ❑ Once in a while ❑ Rarely or never ❑ Don't know

7. Do you have access to your diabetes supplies? ❑ No ❑ Yes: Pharmacy_____

8. Do you test your urine for sugar or ketones? ❑ No ❑ Yes: How often_____

9. How important is it to you to monitor your blood sugar at least once per day, where **0** is not important at all and **10** is very important? *(Circle one)*:
   0 1 2 3 4 5 6 7 8 9 10

10. How sure are you that you can monitor your blood sugar at least once per day, where **0** is not sure at all and **10** is very sure? *(Circle one)*:
    0 1 2 3 4 5 6 7 8 9 10

Taking Medications

1. Do you take pills for your diabetes? ❑ No ❑ Yes: What times?_____

2. Any side effects from the medications that you know of? ❑ No ❑ Yes:_____

3. Do you take any additional nutritional supplements? ❑ Vitamins ❑ Herbal supplements

   ❑ Other:_____

   Have you ever forgotten to take your diabetes medication? ❑ No ❑ Yes: How often?_____

4. Do you take insulin? ❑ No (If NO proceed to question #6)

   ❑ Yes Do you inject insulin with: ❑ Syringe ❑ Insulin pen ❑ Insulin pump

   Who fills the syringe?_____Who gives the injection?_____

   What injection sites are used?_____

   Where do you keep the insulin?_____

   Do you reuse your syringes? ❑ No ❑ Yes If "yes," how often?_____

   Where do you dispose your syringes?_____

5. Have you ever forgotten to take your insulin? ❑ No ❑ Yes: How often?_____

6. How important is it to you to take your medicines, where **0** is not important at all and **10** is very important? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

7. How sure are you that you can take your medicines, where **0** is not sure at all and **10** is very sure? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

Problem Solving

1. Have you ever had a low blood sugar reaction?
   ❑ No ❑ Yes: How often? ❑ Rare ❑ 1-2 times per week ❑ Daily ❑ Other_____

   If "yes," how did you feel?_____

   How did you treat it?_____

   Did you require assistance or hospitalization for it? ❑ No ❑ Yes: When/Where?_____

2. Do you carry a source of sugar with you? ❑ No ❑ Yes If "yes," what kind?_____

3. Have you ever had to give Glucagon? ❑ Don't Know ❑ No ❑ Yes

4. Does someone who lives with you know how to give Glucagon? ❑ Don't Know ❑ Yes ❑ No

5. Do you have an identification that says you are diabetic? ❑ Don't Know ❑ Yes ❑ No

6. Have you ever had high blood sugar? ❑ Don't Know ❑ Yes ❑ No

   If "yes," how did you feel?_____

   What did you do to treat it?_____

   Have you ever been hospitalized for very high blood sugar? ❑ No ❑ Yes

   When/Where:_____

7. When you are sick or cannot eat usual food, how do you take care of yourself?
   ❑ Replace usual food with carbohydrate or sugar ❑ Take diabetes medication ❑ Check ketone levels
   ❑ Check blood sugar more often ❑ Drink more water ❑ Contact healthcare provider

   ❑ Do nothing ❑ Other_____

Stress

1. Is there much stress in your life? ❑ No ❑ If "yes," explain:_____

2. What do you do to handle stress in your life?_____

3. How important is being able to problem solve when being faced with everyday and/or challenging decisions, where **0** is not important at all and **10** is very important? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

4. Do you feel you can problem solve when faced with everyday and/or challenging decisions, where **0** is not sure at all and **10** very sure? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

5. Do you perceive problems with your diabetes management, where **0** is none perceived and **10** is perceive many? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

Healthy Coping

1. How would you describe your general health? ❑ Good ❑ Fair ❑ Poor
2. Is your health important to you? ❑ All the time ❑ Sometimes ❑ Only when ill ❑ Not at all
3. How do you feel about having diabetes?_____
4. Do you feel diabetes is serious? ❑ Yes ❑ No
5. Do you feel you can control your diabetes? ❑ Yes ❑ No
6. Is good control worth it? ❑ Yes ❑ No
7. My diabetes has caused problems in the following areas: ❑ Family life/social activities ❑ Work/school
   ❑ Sports/exercise ❑ Sexual relations ❑ Finances ❑ Contentment ❑ Travel

   ❑ None ❑ Other:_____
8. DURING THE PAST MONTH have you experienced any of the following and to what degree?
   1 – Not a Problem 2 – A Slight Problem 3 – A Moderate Problem 4 – Somewhat Serious Problem
   5 – A Serious Problem 6 – A Very Serious Problem

   1) Feeling overwhelmed by the demands of living with diabetes *(Circle one)*: 1 2 3 4 5 6

   2) Feeling that I am often failing with my diabetes routine *(Circle one)*: 1 2 3 4 5 6
9. Are you currently experiencing any of the following?
   ❑ No problems ❑ Recent death
   ❑ Separation ❑ Divorce ❑ Illness ❑ Unemployment
   ❑ Financial difficulties ❑ Housing problems ❑ Loneliness ❑ Confusion

   ❑ Depression symptoms ❑ Thoughts of hurting yourself ❑ Other:_____
10. Do you have history of depression? ❑ No ❑ Yes: How often do you feel depressed?
    ❑ A lot ❑ Some ❑ A little ❑ Not at all

Reducing Risks

1. How often do you have your eyes checked by an eye doctor?_____ Date of last exam (with drops in the eyes):_____
2. Do you wear glasses? ❑ No ❑ Yes: For what? _____
3. Have you noticed any changes in your skin recently? ❑ Yes ❑ No

   If "yes," please describe:_____
4. How often do you check your feet at home? ❑ Daily ❑ Weekly ❑ Never ❑ Other:_____

   Date of last foot exam by doctor:_____
5. How often do you have a dental checkup?_____ Date of last checkup:_____
6. Have you ever had a shot to prevent pneumonia? ❑ No ❑ Yes: When:_____
7. Have you received a flu shot within the year? ❑ No ❑ Yes: When:_____
8. Have you had your blood pressure checked? ❑ No ❑ Yes: When:_____

9. Have you had a fasting glucose (blood sugar) checked? ❑ No ❑ Yes: When:_____

10. Have you had your cholesterol and triglycerides checked? ❑ No ❑ Yes: When:_____

11. Have you had an A1c test done? ❑ No ❑ Yes: When:_____

12. Do you wear a bracelet or keep something with you that identifies you as having diabetes? ❑ Yes ❑ No

13. Do you have a Diabetes Emergency Plan? ❑ Yes ❑ No

14. How sure are you that you can get the help you need to prevent or reduce problems related to diabetes, where **0** is not sure at all and **10** is very sure? *(Circle one)*:
    0 1 2 3 4 5 6 7 8 9 10

Goal Setting

1. What areas of diabetes would you like to learn more about?
    ❑ What is diabetes? ❑ Pills for diabetes ❑ High blood sugar ❑ Low blood sugar ❑ Diet
    ❑ Exercise ❑ Stress ❑ Sick Days ❑ Pregnancy ❑ Blood testing
    ❑ Complications ❑ Insulin Pumps ❑ Emergency Preparedness

2. Having diabetes means you may need to make changes; if any, what changes would you like to make now?
    ❑ Being active ❑ Eating healthily ❑ Medication taking
    ❑ Monitoring ❑ Living with diabetes ❑ Using healthy coping strategies
    ❑ Problem solving for blood sugars and sick days ❑ Reducing risks of diabetes complications

    ❑ None of the above ❑ Other:_____

Women Only

1. Date of last Pap smear/pelvic exam:_____ Last mammogram:_____

2. How many pregnancies have you had?_____ Abortions/miscarriages:_____

3. How many living children do you have?_____ Complications of pregnancy?_____

4. Were you ever told you had diabetes in pregnancy? ❑ No ❑ Yes

5. Did you have any children that weighted over 9 pounds at birth? ❑ No ❑ Yes

What method of birth control do you use?
    ❑ No method is used ❑ Postmenopausal ❑ Birth control pills ❑ Condoms
    ❑ Norplant/Implanon/Nexplanon ❑ Tubal ligation ❑ Depo-Provera shots ❑ IUD
    ❑ Other:_____

Women Only: Pregnancy

1. Are you currently pregnant? ❑ No ❑ Yes If "yes," what is your due date?_____

2. When was your last menstrual period?_____

3. Are you planning to become pregnant? ❑ No ❑ Yes
    If "yes," are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes? ❑ No ❑ Yes