THEDACARE DIABETES EDUCATION QUESTIONNAIRE

Name: ___________________________ Date of Birth: ___ / ___ / _____ Date: ______________________

What do you expect from this visit today? ____________________________________________________

What is your main concern(s) about managing your diabetes? ______________________________________

SECTION I – Current Diabetes Management

Year you were diagnosed: __________________

How did you find out you had diabetes? ______________________________________________________

Have you ever had diabetes education? □ No □ Yes

Where? ____________________________ When? ____________________________

Date of last dilated eye exam: _______ Last dental exam _______ Last foot exam ______________________

NUTRITION

Has your weight changed in the past year? □ No □ Yes If yes, how much? ____________________ (gain/loss)

Have you made any diet changes since you’ve had diabetes? ________________________________

Do you have any other diet restrictions you follow? __________________________________________

How often do you eat out? ____________________________

What type of restaurants do you eat at? _____________________________________________________

Please list the times of your meals and snacks. Also include examples of foods and beverages you might eat (please include amounts).

TIME

MY TYPICAL MEALS AND SNACKS

I get up at:

I eat Breakfast at: Breakfast:

I eat a Morning Snack at: Morning Snack:

I eat Lunch at: Lunch:

I eat an Afternoon snack at: Afternoon snack:

I eat Dinner at: Dinner:

I eat an Evening/bedtime snack at: Evening/bedtime snack:
EXERCISE
Do you exercise? □ No □ Yes
Type of exercise: ____________________________________________
How many times per week? ________________________________
How many minutes per time? _______________________________
Do you have to limit your exercise because of any physical/health problems? □ No □ Yes
If yes, please explain: _______________________________________

ORAL DIABETES MEDICATIONS – Complete Only If Taking Diabetes Pills

<table>
<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Times Taken</th>
<th>When Started</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Side effects? □ No □ Yes If yes, describe: ________________________________

INSULIN – Complete Only If Taking Insulin At Home

List type and amount you take at each time of day (e.g. Lantus 25 units):
Breakfast ___________________________ Lunch ___________________________
Supper ___________________________ Bedtime ___________________________
Do you use any guidelines for adjusting your insulin? □ No □ Yes If yes, describe: _______________________________________

When did you start taking insulin? ___________________________ Where do you store your insulin? ___________________________
What sites do you use to give your insulin? (i.e. abdomen, legs, arms) ___________________________

SELF BLOOD GLUCOSE MONITORING - Complete Only If Testing Blood Sugars At Home

What type of meter do you use? _______________________________________
How often and when do you check your sugar? ___________________________
Please list your home blood sugar test result ranges (e.g. 90-145):
Breakfast ___________________________ Lunch ___________________________
Supper ___________________________ Bedtime ___________________________
Do you record your blood sugars? □ No □ Yes
Do you have a target blood sugar range? □ No □ Yes If yes, what is the range? ____ - ____ mg/dl
Do you have guidelines for when to call your doctor with high or low test results? □ No □ Yes If yes, what are your guidelines? _______________________________________

What was the result of your last Hemoglobin A1c (HbA1c)? _______% When was it done? ___________________________
Do you ever check for ketones? □ No □ Yes If yes, when? ___________________________
HYPOGLYCEMIA (LOW BLOOD SUGAR) - Complete Only If You Take Diabetes Pills or Insulin

Do you have any low blood sugar reactions?  □No  □Yes If yes, how often?______________________________

When do these reactions tend to occur?______________________________

What warning signals do you feel when you have low blood sugar?______________________________

How do you treat low blood sugar reactions?______________________________

Do you always carry a sugar source with you?  □No  □Yes If yes, what?______________________________

Do you wear diabetes identification?  □No  □Yes

Have you ever become unconscious with a low blood sugar?  □No  □Yes

Do you have a glucagon kit at home?  □No  □Yes

Have you been hospitalized in the past year for your diabetes?  □No  □Yes If yes, please describe:______________________________

SECTION II – Personal History

Race:  □White Caucasian  □Native American  □Black or African American  □Asian  □Latino/Mexican

What level of schooling have you completed?  □Elementary School  □High School  □College or Technical School  □Other______________________________

What is your occupation?______________________________

Hours worked per week: ________Do you work various shifts?  □No  □Yes  If yes, please specify:______________________________

Do you use alcohol?  □No  □Yes If yes, type(s), amount, and times per week:______________________________

Do you use tobacco?  □No  □Yes If yes, amount per day:______________________________

Are you thinking about quitting?  □No  □Yes

Do you use street drugs?  □No  □Yes If yes, type(s), amount, and times per week:______________________________

SECTION III – Psychological/Social Assessment

Number in household:______________________________Relationships:______________________________

Who is a supportive person for you?______________________________

Will a significant other/family member participate in program?  □No  □Yes, Relationship______________________________

Do you have any psychological or social issues/concerns that affect your ability to manage your diabetes?

Please explain:______________________________

SECTION IV - Medical History – Complete This Section Only If Your Physician Is Not A ThedaCare Physician

List all of your non-diabetes medications, including over-the-counter medications and vitamins/mineral supplements:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Do you have allergies to any medications?  □No  □Yes If yes, what kind?______________________________
Do you have any of the following health concerns? (please check)

- Thyroid disease
  Please explain: ____________________________

- Heart disease
  Please explain: ____________________________

- High blood pressure
  Please explain: ____________________________

- High cholesterol
  Please explain: ____________________________

- Eye or vision problems
  Please explain: ____________________________

- Kidney or bladder problems
  Please explain: ____________________________

- Foot problems
  Please explain: ____________________________

- Numbness/pain in: (circle) Hands Feet Legs
  Please explain: ____________________________

- Other
  Please explain: ____________________________

Do you have a family history of:

- Diabetes
  □ No □ Yes If yes, who? ____________________________

- Thyroid disease
  □ No □ Yes If yes, who? ____________________________

- Heart disease
  □ No □ Yes If yes, who? ____________________________

- Other illnesses
  □ No □ Yes If yes, type of illness and who? __________

List surgeries and/or hospitalizations in past year (include dates):
________________________________________________________________________________________
________________________________________________________________________________________

Patient Signature: ____________________________