THEDACARE DIABETES EDUCATION QUESTIONNAIRE

What concerns you most about your diabetes?

____

____

What are you most interested in learning/achieving from these diabetes education sessions?
___diet ___exercise ___blood sugar testing ___complications ___other ____________________

____

SECTION I –Diabetes History

What year/age were you diagnosed? ____

What type of diabetes do you have? ___Type 1 ___Type 2 ___Gestational, during pregnancy
___I don't know

How did you find out you had diabetes? __blood test ___diabetes symptoms (thirsty, tired, frequent urination) ___other: explain____

Family members with a history of diabetes: __mother __father __sibling(s) __grandparent(s)
__aunt/uncle __other, List____

Have you ever had diabetes education? __Yes __No

How long ago? ____

Where? ___ ThedaCare ___ Other, where? ____

Check any of the exams you have had in the last 12 months:
___dilated eye exam ___dental exam ___foot exam

NUTRITION

Has your weight changed in the last year? ___gain ___loss ___weight fluctuates, how much? _____
___no change

Do you have a meal plan for diabetes? ___yes ___no

If yes, describe____

How often do you use this plan (% of time)? __<25% __25-49% __50-74% __75+%

Do you have any other diet restrictions you follow?

____

Who does your food shopping? __self __spouse __parent __child __significant other __friend,
__other____

Who cooks your meals? __self __spouse __parent __child __significant other __friend __ meals on wheels, __ other____

How often do you eat out? __< once/week __once/week __2-3 times/week __>4 times/week

Write down examples of your meals, snacks and beverages for a typical day:

Time: ___________ Breakfast: ____

Time: ___________ Snack: ____

Time: ___________ Lunch: ____

Time: ___________ Snack: ____

Time: ___________ Dinner: ____

Time: ___________ Snack: ____

Beverages: ____

____

EXERCISE

Do you exercise? __ Yes __ No

Type of exercise: __walk __bike __swim __sports __other, list: ____________________

How many times per week? __1 __2 __3 __4 __5 __6 __7

How many minutes per time? __5 __10 __15 __20 __25 __30 __35 __40 __45 __50 __55 __60 __ other ___________

Do you have to limit your exercise because of any physical/health problems? __ No __Yes

If yes, please explain:

____

____

DIABETES MEDICATIONS/INSULIN

Do you wear an insulin pump? __ no __ yes, Type of pump __Medtronic __Tandem __ Omnipod __ other ____________

Do you take diabetes medications/insulin? ___yes ___ no

If yes, about how often do you miss taking your medicine? __ Never __Rare __Often __Daily

List your diabetes medications/insulin:

Name	Dose	When Taken

Do you have any <u>diabetes medication</u> side effects? __No __Yes If yes, describe:

____

If you use insulin, do you use any guidelines for adjusting your insulin? __No __ Yes, describe:

____

If you take injectable diabetes medication, where do you store it? ____________________

Check which sites you use to give your injectable medications: ___abdomen, ___legs, ___arms, ___buttocks

HOME GLUCOSE MONITORING

Do you check your sugar levels at home? ___yes ___no

Check the devices you use to check sugar levels: ___finger stick glucose meter ___continuous glucose sensor

Name of meter/monitor you use? ____

How often and when do you check your sugar? __1x/day __2x/day __3-4x/day __3-4x/week, __infrequent __continuously with sensor

Please list your recent home blood sugar test result ranges (e.g. 90-145)

Breakfast________________________________Lunch____________________________________

Supper__________________________________Bedtime__________________________________

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? __________% When was it done?

____

If you take insulin, do you ever check for urine ketones? __ No __ Yes If yes, when?

____

HYPOGLYCEMIA (LOW BLOOD SUGAR) - <u>Complete Only If You Take Diabetes Medication</u>

How often have you had a low blood sugar (<80)? ___Never ___Once a month ___One or more times a week

When do your low sugars tend to occur? __daytime __night __after activity __after missing meal __other, explain____

What warning signals do you feel when you have low blood sugar? __weak __shaky __sweaty __dizzy __other, list: ____

How do you treat your low blood sugar?

____

Do you always carry a sugar source with you? __No __Yes, what?

____

Do you wear diabetes identification? __ No __Yes

Have you ever become unconscious with a low blood sugar? __No __ Yes

If taking insulin, do you have a glucagon kit at home? __ No __Yes

Have you been hospitalized in the past year for your diabetes? __ No __ Yes, please describe:

____

SECTION II – Personal History

Race (check all that apply) __ White Caucasian __ Native American __ Black or African American Asian __Hispanic ___Middle-Eastern __Other

Do you have any cultural/religious practices or beliefs that affect how you care for your diabetes?

___no ___yes, describe____

What is your language preference? ___English ___Other, list ______________________________

What level of schooling have you completed? __ Elementary School __High School

__ College or Technical School __Other

How do you learn best? __ Listening ___Reading ___Observing ___ Doing

Check any you have: Difficulty with: __Hearing __Seeing ___Reading ___Speaking __Writing ___Understanding

Explain any checked barriers: ____

What is your occupation? ____

Do you work various shifts? __ No __Yes If yes, please specify: ____________________________

Do you use alcohol? __ No __ Yes, type(s), amount, and times per week:

____

Do you use tobacco? __ No __ Yes, amount per day:

____

Are you thinking about quitting? __ No __ Yes

Do you use street drugs? __No __ Yes, Type(s), amount, and times per week:

____

SECTION III – Psychological/Social Assessment

Number in household: __1 __2 __3 __4__5 __6+ Relationships: __ Significant other __ Spouse __Children __Parent ___Grandchildren ___ Other

From who do you get support for your diabetes? ___ Family ___Friends ___Coworkers ___Health Care Providers ___Online ___No-one

Do you have any psychological or social issues/concerns that affect your ability to manage your diabetes? __No ___Yes, please explain:

____

Do you have trouble paying for your medications or health care now or have concerns about paying for them in the future? __No ___Yes, please explain:

____

____