BROOKHAVEN MEMORIAL HOSPITAL

DIABETES WELLNESS CENTER

33 Medford Avenue (second floor), Patchogue, NY 11772
Phone (631) 687-4188 Fax (631) 687-4199

PARTICIPANT SELF-ASSESSMENT OF DIABETES MANAGEMENT

NAME:	**DATE:**
ADDRESS:	**CITY:** **STATE:** **ZIP:**
PHONE: (Home) (Cell)	
Date of Birth: ____/____/____ **AGE: _____**	**Ethnic Background**: Caucasian / African American / Asian Hispanic / Native American **Primary Language:** **Gender:** Male Female

Medical / Medication / Lifestyle -

Type of diabetes: Type 1 Type 2 Prediabetes (circle one) Gestational I don't know	**Year / Age Diabetes Diagnosis: _____ / _____** **HEIGHT _____ WEIGHT _____**
Any other medical History? _____ _____ _____	**Medications: (circle all that apply)** Byetta / Victoza injections Symlin injections Insulin injections / Oral medications Combination of insulin and oral medications
Do you have any of the following problems? Circle all that apply Eye problems / Dental problems / Depression Kidney problems / High blood pressure High cholesterol / Sexual problems Tingling. Numbness, loss of feeling in feet	**Please list all other medications you take:** _____ _____ _____ _____ _____
How often do you miss taking your medications as prescribed? _____	
Any Emergency room visits or hospital admissions LAST 12 MONTHS? YES NO **Was the ER visit or hospital admission DIABETES RELATED?** YES NO	
I had the following done in the last 12 months Circle all that apply Dilated Eye exam / Foot Exam / Dental exam **A**1C level / **B**lood pressure / **C**holesterol Weight / Urine checked for protein Flu shot / Pneumonia shot	**Do you drink alcohol?** YES NO ____drinks per day / week / occasionally **Do you smoke?** YES NO **(Circle all that apply)** cigar / cigarettes / chewing Pipe / none / Quit- how long ago__

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Employment / Education / Support -

Currently employed?: YES NO **Occupation: _____**	**Marital status:** Single / Married / Divorced / Widowed
Level of education: _____ **(specify last grade in school)**	**I learn best by: (circle all that apply)** Reading / Audio visual / Interactive discussion Observing / Listening
I have a computer: YES NO **I am able to use a computer:** YES NO	**Any cultural or religious practices that may influence how you care for your diabetes?** YES NO **Please describe:_____**
Do you have any difficulty in: **Circle all that apply and explain what is circled** Seeing / Reading / Hearing / Speaking / No difficulties **EXPLAIN: _____**	
Who do you live with? _____ **Who do you look towards for support? _____** **Any family with Diabetes?_____**	

Diabetes Monitoring / Exercise -

Any previous instructions on diabetes? YES NO **If yes, How long ago? _____**	**In your own words, what is diabetes?** _____ _____
Do you check your blood glucose? YES NO **What is your range?** **_____** to **_____**	**How often do you check your blood glucose?** Once a day / Twice a day / 3-4 times a day / Weekly / Occasionally Never / Other _____
What is your target range for your blood glucose? _____	**When do you check your blood glucose? Circle all that apply** Before breakfast / Before bedtime / 2 hours after a meal Before each meal
Can you tell if your blood glucose is too LOW? YES NO **Can you tell if your blood glucose is too HIGH?** YES NO	**Within last month, how many episodes of LOW BLOOD glucose did you experience?** Once / Once or more times per week / Never **What were your symptoms? _____** **How do you treat LOW BLOOD glucose? _____**
How often do you regularly exercise? Once a week 2 more times a week	**What is your exercise routine? (running, walking, etc)** _____ **My routine is**: Easy / Moderate Intense / Very Intense

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Diet -

Do you read food labels as a dietary guide? YES NO	**Do you have a meal plan for diabetes?** YES NO **If yes, please describe;** _____ _____ _____
Do you do your own food shopping? YES NO	**How often do you use this meal plan?** Never / Seldom / Sometimes / Usually / Always
Do you have any diet restrictions? **(Circle what applies)** Salt / Fat / Fluid / None **Other** _____	**Do you cook your own meals?** YES NO **How often do you eat out?** _____

GIVE A SAMPLE OF YOUR MEALS FOR A TYPICAL DAY (Within 24 hours)

DAY	TIME	What did you eat and drink	HOW MUCH Try to use exact amount Or use cups. Ounces pieces, slices

Pregnancy and Fertility -

Are you: Pre – menopausal Menopausal Post Menopausal N/A	
Are you Pregnant? YES NO **If yes, when expecting?** _____	**Are you planning to become pregnant?** YES NO
Do you have any children? YES NO	**Have you been pregnant before?** YES NO
Are you using birth control? YES NO	**Are you aware of the IMPACT of diabetes on pregnancy?** YES NO

Coping skills -

I feel good about my health **(Circle one)** Agree Disagree Neutral	**My main concern about my diabetes is** _____ _____ _____
My stress level is high **(Circle one)** Agree Disagree Neutral	**I handle stress by** _____ _____ _____
My diabetes interferes with other aspects of my life **(Circle one)** Agree Disagree Neutral	**The hardest part in caring for my diabetes is** _____ _____ _____ _____ _____
I have some control over whether I get diabetes complications or not **(Circle one)** Agree Disagree Neutral	**My thoughts and/or feelings about diabetes is** _____ _____ _____ _____
I struggle with making changes in my life in order to care for my diabetes **(Circle one)** Agree Disagree Neutral	**What I want to learn from the Diabetes Education Session is** _____ _____ _____ _____ _____

*** PLEASE DO NOT WRITE BELOW THIS LINE ***		
CLINICAL ASSESSMENT SUMMARY		
Office use only **EDUCATION NEEDS / EDUCATION PLAN**		
☐ **Diabetes Disease Process**	☐ **Using medication**	☐ **Risk Reduction Strategies**
☐ **Nutrition Management**	☐ **Monitoring Prevention**	☐ **Behavior Changes Strategies**
☐ **Physical Activity**	☐ **Acute Complications**	☐ **Psychosocial Adjustment**
☐ **Preventing Chronic Complications**		
DATE:	**Clinical Signature:**	
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