TMH PHYSICIAN PARTNERS

# TALLAHASSEE MEMORIAL DIABETES SERVICES
# DIABETES SELF-MANAGEMENT QUESTIONNAIRE

**Name:** _____ **Date of birth:** _____ **Age:** _____ **Race:** _____

❒ **Male** ❒ **Female What language do you prefer to use in discussing your health care?** ❒**English** ❒**Other** _____

**Preferred contact number**_____ **(work/home/cell) Alternate contact number**_____ **(work/home/cell)**

**Address:** _____

**Name of emergency contact:** _____ **Phone:** _____

**Primary Care Physician:** _____ **Referring Physician:** _____

**Please specify any religious/cultural or personal health beliefs that you would like considered as we help you develop your diabetes care plan:** _____

## MEDICAL HISTORY

**When were you diagnosed with diabetes?** _____ ❒ **Type 1** ❒ **Type 2** ❒ **Pre-diabetes** ❒ **Unsure**

**Do you have a family history of diabetes?** ❒ **YES** ❒ **NO**

**Treatment for diabetes:** ❒ **Diet/exercise alone** ❒ **Pills** ❒ **Insulin** ❒ **Pills and insulin** ❒ **Pump**

**Do you have any questions about your medication?** ❒ **YES** ❒ **NO**

**Do you test your blood sugar at home?** ❒ **YES** ❒ **NO (Meter type:** _____**Test times:**_____**)**

**What problem, if any, do you have with blood sugar testing:** _____

**Do you have any of the following complications of diabetes or other medical conditions?**

❒ **Foot problems (Specify:** _____**)** ❒ **Heart disease** ❒ **Hypertension** ❒ **High cholesterol/triglycerides**
❒ **Eye problems (Specify:** _____**)** ❒ **Arthritis** ❒ **Kidney** ❒ **TB** ❒ **MRSA** ❒ **Thyroid problems**
❒ **Cancer (Specify:** _____**)** ❒ **Neuropathy** ❒ **Sleep apnea** ❒ **Asthma/breathing problems**
❒ **Depression/anxiety** ❒ **Erectile dysfunction** ❒ **Liver disease** ❒ **Epilepsy** ❒ **Mental health issues** ❒ **GERD/acid reflux**
❒ **Other (Specify:** _____**)**

**List any surgeries that you have had and the year of each:**

_____

_____

**Have you been hospitalized during the past 12 months?** ❒**Yes** ❒**No (Please explain:** _____

_____**)**

**When did you last have your feet checked by a doctor?** _____

**How often do you inspect your feet?** ❒ **Daily** ❒ **Few times a week** ❒ **Once a week** ❒ **Sometimes** ❒ **Rarely**

**When did you last see an eye doctor for a dilated eye exam?** _____

**For women of child-bearing age, do you use birth control?** ❒ **YES** ❒ **NO** ❒ **Does not apply to me** **Do you plan to become pregnant in the next year?** ❒ **YES** ❒ **NO** **Have you received any diabetes pre-pregnancy information?** ❒ **YES** ❒ **NO**

**Patient Name:** _____ **DOB:** _____

**SOCIAL HISTORY**

**Occupation:** _____ **Work shift:** _____

**Number of persons in your household:** _____ **Relationship and age(s):** _____

_____

**Do they help you in caring for your diabetes? ❒ YES ❒ NO (Explain:** _____**)**

**Have you had diabetes teaching before? ❒ YES ❒ NO (Where/when?** _____**)**

**What do you want to learn in diabetes class?** _____

**Are you in a family situation in which you fear for your safety? ❒ YES ❒ NO**

**Hobbies/Interests:** _____

**How do you learn best? ❒ Reading ❒ Listening ❒ Demonstration ❒ Hands-on ❒ Other:** _____

**How does having diabetes make you feel?** _____

**List sources of stress in your life:** _____

**Consider the degree to which each of the two items below may have distressed or bothered you and circle the appropriate number.**

| | Not a problem | Slight problem | Moderate problem | Somewhat serious problem | Serious problem | Very serious problem |
|---|---|---|---|---|---|---|
| Feeling overwhelmed by the demands of living with diabetes. | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling that I am often failing with my diabetes routine. | 1 | 2 | 3 | 4 | 5 | 6 |

**HABITS**

**Have you been advised by your health care provider/physician to be physically active? ❒ YES ❒ NO ❒ Restrictions**
**Please rate your daily activity level: ❒ Mild ❒ Moderate ❒ Active Do you have a regular exercise program? ❒ YES ❒ NO**
**Do you smoke or chew tobacco? ❒ YES ❒ NO (Amount per day:** _____**)**
**Do you use recreational drugs (Marijuana** _____**)? ❒ YES ❒ NO (How often?** _____**)**
**How many alcoholic drinks do you have per week?** _____

**NUTRITION**

**Has your weight changed in the last year? ❒ Gained:** _____ **pounds ❒ Lost:** _____ **pounds ❒ Goal weight:** _____ **pounds**

**Are you allergic to any foods? ❒ YES ❒ NO (Specify:** _____**)**

**Have you changed your eating habits since finding out that you have diabetes? ❒ YES ❒ NO**

**Are you following a diet? ❒YES ❒ NO (Specify:** _____**) Please list your experience with diets in the past:** _____

**How often do you eat out?** _____ **times per week (Specify:** _____**fast foods;** _____**buffets;** _____**sit-down restaurants)**

**Have you identified problems with your eating habits? ❒ YES ❒ NO (Specify:** _____**)**

**Do you drink sugar sweetened beverages (Gatorade, Kool-Aid, tea, soda, etc.)? ❒ YES ❒ NO**

**Assessment completed by ❒patient ❒family member ❒clinician**

**CLINICIAN SIGNATURE**_____**DATE/TIME:** _____