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

Name	Dosage	Times Taken	When Started

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: _____

THEDACARE DIABETES EDUCATION PROGRAM

DIABETES
What Do You Know?

Name: _____
Pre-test _____ Post-test ____
Score _____

The following quiz is to give us an idea about your baseline understanding of diabetes. Please circle the letter that best completes the statement. If you are unsure of the answer, please circle "d" as this is not a wrong answer but helps us to know how to best meet your educational needs. Thank you.

1. The usual cause of diabetes is:
   a) Eating too much sugar and other sweet foods.
   b) Lack of or ineffective use of insulin in the body.
   c) Failure of the kidneys to control sugar in the urine.
   d) I don't know.

2. The ideal blood glucose range before meals for a person with diabetes is:
   a) 90 - 130 mg/dl
   b) 40 - 70 mg/dl
   c) 150 - 200 mg/dl
   d) I don't know.

3. The main source of carbohydrate in the diet is:
   a) Fat and oil
   b) Vegetables
   c) Bread and cereal
   d) I don't know

4. The effect of exercise is to:
   a) Lower the blood sugar level
   b) Raise the blood sugar level
   c) Increase sugar in the urine
   d) I don't know

5. Oral medications used in treating diabetes:
   a) Can substitute for diet and exercise for lowering blood sugars
   b) Are insulin pills
   c) Stimulate the release of insulin or make the body's insulin work more effectively.
   d) I don't know.

6. The best way to assess your diabetes control is:

   a) A written record of daily blood sugar tests.
   b) Random urine test results
   c) A single blood sugar test
   d) I don't know

7. If a diabetic person experiences symptoms of **hypoglycemia (low blood sugar)**, he should immediately:

   a) Take some insulin
   b) Lie down and rest
   c) Eat or drink some form of sugar
   d) I don't know

8. Early symptoms of **hyperglycemia (high blood sugar)** may be?

   a) Convulsions and sweating
   b) Excessive thirst and frequent urination
   c) Coma
   d) I don't know

9. <u>During illness</u> it is important to test your blood sugar more often, drink more fluids and take your diabetes medications as ordered because:

   a) Blood sugars tend to rise
   b) Blood sugars tend to go low
   c) Illness tends to increase the secretion of insulin
   d) I don't know

10. Complications of diabetes such as: kidney, eye, and heart disease:

    a) Occur in all patients with diabetes; they are unavoidable
    b) Don't occur until old age
    c) Can be delayed/prevented by keeping blood sugars within an acceptable range
    d) I don't know

11. Good care of the feet is important because people with diabetes often have:

    a) Varicose veins
    b) Corns and calluses
    c) Poor circulation
    d) I don't know

12. Proper diabetes management can be obtained by:

    a) Following a healthy meal plan
    b) Regular exercise
    c) Both of the above
    d) I don't know