ThedaCare™

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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:

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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? _____

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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? _____

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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: _____