Addressograph Area

PREDIABETES SELF-ASSESSMENT

DIABETES CENTRE (DC)

Name: _____

Date of Birth: _____ _____ _____
day month year

Instructions for Completing this Questionnaire

Thank you for completing this questionnaire at home. This information is important in helping us get to know you and will also allow more time for us to talk with you at your appointment. **An appointment has been arranged for you at the Diabetes Centre on _____.**

1. **Please print clearly**. If you have any problems, have someone help you complete the form.
2. Please follow the instructions in the cover letter for returning this form to your Diabetes Centre.
3. If you are unsure about any questions on this form, please call the Diabetes Centre at _____.
4. Please bring the following with you to your **first appointment**:
   - Your completed **nutrition questionnaire/food record** (enclosed).
   - Your Nova Scotia Health Card.
   - The **completed Medication Sheet** (enclosed).
   - Your reading glasses (if worn).

DIABETES-RELATED INFORMATION (please print):

When did you find out that your blood sugar was above normal? _____ (month) _____ (year)

Do you have a family history (parents, sisters/brothers, or children) of the following:

Diabetes	❑ No	❑ Don't know	❑ Yes	If yes, who: _____
Heart disease	❑ No	❑ Don't know	❑ Yes	If yes, who: _____
High blood pressure	❑ No	❑ Don't know	❑ Yes	If yes, who: _____
Obesity	❑ No	❑ Don't know	❑ Yes	If yes, who: _____

HEALTH STATUS (please print):

Do you take any medications (including vitamins or supplements)? ❑ No ❑ Yes

If yes, fill in the enclosed medication sheet.

Are you **allergic** to anything? ❑ No ❑ Yes

Drug: _____ Food: _____

Other: _____

HEALTH STATUS (cont):

Have you been seriously ill or **in the hospital in the last 12 months**? ❑ No ❑ Yes

If yes, what was this illness or the reason for your stay? _____

_____

Do you have any of the following **health problems**? Please check (√) the appropriate box(es).

❑ **None**

❑ Hearing problems	❑ Breathing problems	❑ Kidney problems
❑ Eye or vision problems	❑ Circulation problems	❑ Urinary infections
❑ High blood pressure	❑ Arthritis	❑ Bladder problems
❑ Heart problems	❑ Cancer	❑ Bowel problems
❑ Stroke	❑ Depression	❑ Thyroid problems
❑ Cholesterol problems	❑ Chronic pain	❑ Other: _____

Have you ever been diagnosed with gestational diabetes? ❑ No ❑ Yes

Do you **smoke**? ❑ No ❑ Yes If yes, how much? _____
Cigs or packages per day (Circle one)

Did you ever smoke? ❑ No ❑ Yes When did you quit? _____

Do you drink **alcohol**? ❑ No ❑ Yes If yes, what do you drink? _____

How much and how often? _____

Do you use **social drugs** (For example, marijuana, hash)? ❑ No ❑ Yes

If yes, what do you use and how often? _____

SOCIAL ASSESSMENT (please print):

Do you **live alone**? ❑ No ❑ Yes If no, whom do you live with? _____

Who do you rely on when you **need help/support**?

❑ spouse/partner ❑ mother or father ❑ friend ❑ other: _____

Do you **work outside the home**? ❑ No ❑ Yes ❑ Retired

If yes, what do you do? _____ ❑ full-time ❑ part-time ❑ shift work

Do you have financial concerns? ❑ **none** ❑ food ❑ other: _____

Do you have a **drug plan?** ❑ No ❑ Yes

Do you have any religious, family, or cultural practices that influence how you care for your health? ❑ No ❑ Yes _____

PHYSICAL ACTIVITY (please print):

Are you **physically active**? ❑ No ❑ Yes ❑ Advised not to by Doctor

Type of activity/exercise? _____

How often do you do it? _____

Do you have any specific hobbies/recreational interests? ❑ No ❑ Yes

If yes, please describe: _____

_____

How many hours a day do you spend in front of the TV and/or computer? _____

What stops you from being more active (what are the barriers)? _____

_____

NUTRITION—DIETARY HISTORY (please print):

What is your **usual weight**? _____ pounds/kgs (circle) What would you like to weigh? _____ pounds/kgs (circle)

Has your **weight changed** in the last 6 months? ❑ No ❑ Yes

If yes, how much have you ❑ lost or ❑ gained? _____ pounds/kgs *(circle)*

Have you ever **been on a diet** (meal plan) in the past? ❑ No ❑ Yes

If yes, when and what was it for? _____

_____

Check (√) any of the following **problems**:

❑ Constipation and/or diarrhea Explain: _____

❑ Chewing and/or swallowing Explain: _____

❑ Appetite Explain: _____

Do you eat in **restaurants**? ❑ No ❑ Yes

If yes, how often and what foods do you usually choose? _____

_____

Do you eat in response to ❑ stress and/or ❑ boredom? ❑ No ❑ Yes

If yes, how often and what do you choose? _____

_____

Do you ever **skip meals**? ❑ No ❑ Yes

If yes, how often? _____ (times per week) What meal or meals? _____

Why do you skip meals? _____

NUTRITION—DIETARY HISTORY (cont):

Have you **changed your** eating habits in the **past 6 months**? ❑ No ❑ Yes

If yes, in what way? ❑ how much you eat ❑ types of food you eat ❑ when you eat

Explain: _____

_____

PERSONAL NEEDS (please print):

Do you want to make changes to how you eat or your exercise (if necessary)? ❑ No ❑ Yes

If yes, what changes would you like to make? _____

_____

Please list any specific questions you may have. _____

_____

_____

What would you **most** like to discuss on your first visit? _____

_____

_____

What is the best way **for you to learn new information**?

❑ Listening ❑ Talking ❑ Videos ❑ Reading material ❑ Internet

Person filling out information on this form please sign here:

Name: _____ **Date:** _____

(If someone other than the client, state relationship) (day/month/year)

Thank you for filling out this questionnaire.
We look forward to meeting with you. Thank you!

OFFICE USE ONLY
Name and signature required by those reviewing this form.

Date	Name (Print)	Signature	Initials	Discipline