Addressograph Area

DIABETES 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.
   - Your blood glucose meter and testing supplies.
   - Your record or log book of home blood test results.
   - The **completed Medication Sheet** (enclosed).
   - Your reading glasses (if worn).

DIABETES-RELATED INFORMATION (please print):

When did you find out you have diabetes? _____ / _____
month year

Have you had any previous diabetes education? ❑ No ❑ Yes

If yes, where? _____ When? _____
Name of Diabetes Program **Month/Year**

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

Drugs: _____ Food: _____

Other: _____

Check (√) any of the following **complaints or problems** you have at **present.**

Present Complaints/Problems: ❒ **None**

❒ Increased thirst ❒ Itchy skin ❒ Headache ❒ Need to urinate often
❒ Infections ❒ Blurred vision ❒ Tiredness ❒ Losing weight
❒ Other (please note) _____

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 wear or carry some type of **diabetes identification**? ❒ No ❒ Yes
If yes, type: ❒ Wallet card ❒ Medic Alert® ❒ Other: _____

Do you take any **medications** (including vitamins or supplements)? ❒ No ❒ Yes
If yes, please fill in the enclosed medication sheet.

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 boxes.

❒ **None**
❒ Hearing problems ❒ Circulation problems ❒ Kidney problems
❒ Eye or vision problems ❒ Arthritis ❒ Urinary infections
❒ High blood pressure ❒ Cancer ❒ Bladder problems
❒ Heart problems ❒ Depression ❒ Bowel problems
❒ Stroke ❒ Chronic pain ❒ Thyroid problems
❒ Breathing problems
❒ Cholesterol problems
❒ Numbness or tingling in your body (hands, feet, etc.)
❒ Sexual problems – Would you like information? ❒ No ❒ Yes
❒ Other: _____

HEALTH STATUS (cont)

For Women of Child-Bearing Age (12 to 45 years):

Are you planning a pregnancy? ❑ No ❑ Yes

Are you using birth control? ❑ No ❑ Yes If yes, method: _____

How often do you see the following healthcare providers? Please check (√) the appropriate column or add the necessary information.

	Name	Never	Every 2 to 3 months	Every 6 months	Once a year	Other (How often?)	Last Appointment (month/year)
Family Doctor							
Diabetes Doctor							
Eye Doctor							
Dentist							
Foot Care Provider							

Do you use any **home health-care services** (such as VON, Home Care, Community Health/ Public Health, etc.)? ❑ No ❑ Yes

If yes, what service do you use; and how do they help you? _____

_____

Do you get an annual **flu shot**? ❑ No ❑ Yes Last Date: _____

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** ❑ diabetes supplies ❑ 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 _____

DIABETES TREATMENT (please print):

Do you test your blood glucose at home using a blood glucose meter?

❑ No ❑ Yes If yes, how often? _____

Please bring your meter and test strips to your appointment.

Do you have symptoms of **low blood glucose** (weakness, dizziness, hunger)?

❑ No ❑ Yes If yes, how often does this happen and what time of day?

_____

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

If yes, type of activity/exercise? _____

How often do you do it? _____ What time of day? _____

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**? _____ What would you like to weigh? _____
pounds/kgs (circle) pounds/kgs

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 **seen a dietitian** for a meal plan before? ❑ No ❑ Yes

If yes, when and where? _____

Have you 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? _____

Who does the **grocery shopping?** (check one or more)

❒ self ❒ spouse ❒ other: _____

Who **prepares the meals**? (check one or more)

❒ self ❒ spouse ❒ other: _____

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

If yes, check 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