Duke Primary Care Diabetes Education Program
Diabetes Self-Assessment

Name_____DOB_____Gender___

Have you had diabetes education in the past? ☐Y ☐N If yes, when?_____
When were you diagnosed with diabetes? _____
List relatives with diabetes _____

PSYCHOSOCIAL

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
How many people live in your home? ____ How are they related to you?_____
Are you currently employed? ☐ Yes ☐No
Occupation? _____Do you work shifts? ☐ Yes ☐No
Do you have difficulty with: ☐Hearing ☐Vision ☐Reading ☐Memory ☐Other
Please explain: _____
Who is on your support team? ☐Family ☐Friends ☐Co-workers ☐No one
Do you feel overwhelmed by the demands of diabetes?
☐Not a problem ☐Somewhat ☐Always
How do you handle your stress?_____

NUTRITION

Do you follow a special diet? ☐Yes ☐No
If so, what are your food restrictions? _____
Do you count carbohydrates? ☐Yes ☐No
How many meals do you eat a day? _____How many snacks do you eat a day? ___
Who does the grocery shopping? _____ Who cooks the meals? _____
How many times per week do you eat out? _____
Which type of restaurants? _____
Please provide a sample of your meals and snacks for a typical day:
Time: ____ Meal 1: _____
Time: ____ Snack: _____
Time: ____ Meal 2: _____
Time: ____ Snack: _____
Time: ____ Meal 3: _____
Time: ____ Snack: _____
What do you drink on a regular basis? _____

Sweeteners: ☐Regular sugar ☐Honey ☐Sweet-n-Low ☐Equal ☐Splenda
☐Truvia ☐Other _____

Please Turn Over to Complete →

PHYSICAL ACTIVITY

Do you exercise? ☐Yes ☐No Type of exercise: _____
How many times a week? _____ for how many minutes? _____
Are you active at work? ☐Yes ☐No Please describe activity: _____

DIABETES MEDICATION

Name	Dose (How much?)	What time do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you forget or omit any of your diabetes medications? Please explain
_____

TESTING BLOOD SUGAR

Do you check blood sugar at home? ☐Y ☐N How many times a day?_____
What is the typical range of your blood sugar numbers? _____
Do you have questions about using your monitor? ☐Yes ☐No

HYPERGLYCEMIA

Can you tell when your blood sugar is high? ☐ Yes ☐No
How do you feel?_____

HYPOGLYCEMIA

Does your blood sugar run **too low** sometimes? ☐ Yes ☐No
How often does this happen? _____What are the low numbers?_____
How did you feel? _____ How do you treat this? _____
Do you carry fast acting sugar with you? (glucose tabs, candy, juice) ☐Y ☐N
Do you have a Glucagon kit? ☐ Y ☐N Have you ever needed to use it? ☐Y ☐N

FEET

Do you check feet daily? ☐Yes ☐No
Do you have any problems with your feet? ☐Yes ☐No
If yes, explain: _____
Have you had any nerve damage (neuropathy) from diabetes? ☐Yes ☐No

EYES

When was your last eye exam? _____
Have you had any eye damage (retinopathy) from diabetes? ☐ Yes ☐ No