Diabetes Self-Management Follow-up Assessment

Date:_____

Name (Last, First, MI): _____ Date of Birth: _____

MEDICAL HISTORY

Have there been any changes in your diabetes medication? ☐ Yes ☐ No If yes, please describe:

How often in the past week **did you miss a dose** of your diabetes medication? _____

Have there been any changes to your blood pressure medication? ☐ Yes ☐ No ☐ Not Applicable
If yes, please describe: _____

How often in the past week **did you miss a dose** of your blood pressure medication? _____

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Poor
Do you believe you can improve your health? ☐ Yes ☐ No ☐ Sometimes
What is the most difficult part of managing your health? _____

KNOWLEDGE

How would you rate your understanding of diabetes?
☐ Excellent ☐ Very Good ☐ Good ☐ Average ☐ Minimal

What areas would you like to learn more about? Check all that apply:

- ☐ What is diabetes, how it is diagnosed, how it progresses
- ☐ Nutrition & weight and their impact on blood sugar
- ☐ Medications, how they work (actions & benefits)
- ☐ Monitoring blood sugars, targets, when & why to check it
- ☐ Prevention & treatment of diabetes related complications
- ☐ Physical activity how it impacts blood sugar levels
- ☐ How to change behaviors, goal setting
- ☐ Problem solving, sick days, treating low & high blood sugars
- ☐ Stress & coping, creating a support plan

What is your overall diabetes goal? _____

REDUCING RISKS

In the last year have you had the following? Check all that apply:

☐ Diabetic eye exam Month/ year: _____ ☐ Dental exam ☐ Diabetic foot exam Month/ year: _____ ☐ A1C test ☐ Flu shot

Do you check your blood pressure at home: ☐ Yes ☐ No Typical results: _____

How often do you examine your feet?

☐ Daily ☐ Several times/week ☐ Few times/month ☐ Once in a while ☐ Rarely or never

SUPPORT

Which of the following describes how you feel about having diabetes, check all that apply:

☐ Okay ☐ Distressed ☐ Nuisance ☐ Denial ☐ Depressed

☐ Anxious ☐ Hopeless ☐ Overwhelmed ☐ Other: _____

Describe the amount of stress in your life: _____

How sure are you that you can find the support you need to manage your diabetes?

☐ Very Sure ☐ Somewhat sure ☐ Not at all sure

PHYSICAL ACTIVITY

On average how many **minutes per week** do you participate in aerobic (cardio) activities? _____

☐ Walking ☐ Jogging ☐ Swimming ☐ Cycling ☐ Other: _____

On average how many **days per week** do you participate in muscle strengthening activities? _____

☐ Free weights ☐ Resistance bands ☐ Weight machines ☐ Other: _____

On a scale of zero to ten, how **important** is it to be physically active to help manage your diabetes?
(zero = not important at all, ten = very important): 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using physical activity to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

My physical activity goal is: _____

HEALTHY EATING

Which of these healthy habits are you currently doing? check all that apply:

☐ Read food labels ☐ Include high fiber foods ☐ Count calories

☐ Measure food portions ☐ Choose low sodium foods ☐ Limit saturated/trans fats

☐ Limit sugar-sweetened items ☐ Count carbohydrate grams/serving

☐ Other: _____

How would you rate the quality of your current eating habits?
☐ Excellent ☐ Very Good ☐ Good ☐ Poor

On a scale of zero to ten, how **important** is it to eat healthy to help manage your diabetes?
(zero = not important at all, ten = very important): 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using healthy eating to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

MONITORING

Do you check your blood sugars? ☐ Yes ☐ No

If yes, how often? _____ What time(s) of day do you test? _____

What is the **low to high range** of your blood sugars? _____

How often do you have low blood sugars? _____

How often do you have high blood sugars? _____

On a scale of zero to ten, how **important** is it to check your blood sugar to help manage your diabetes?
(zero = not important at all, ten = very important 0 1 2 3 4 5 6 7 8 9 10

On a scale of zero to ten, what is your **confidence** in using blood sugar readings to help manage blood sugar?
(zero = no confidence, ten = totally confident): 0 1 2 3 4 5 6 7 8 9 10

Do you wear medical identification or keep something with you to identify that you have diabetes?
☐ Yes ☐ No ☐ Sometimes

PROBLEM SOLVING

When you are sick and unable to eat your usual foods, what do you do? check all that apply:

- ☐ Eat/drink foods/liquids with carbohydrates
- ☐ Take diabetes medications
- ☐ Check blood sugar more often
- ☐ Drink more water
- ☐ Check ketone levels
- ☐ Call health care provider
- ☐ None of these
- ☐ Other: _____

QUALITY OF LIFE

On a scale of zero to ten, how do you rate your quality of life?
(zero = very low quality of life, ten = excellent quality of life): 0 1 2 3 4 5 6 7 8 9 10

Client Signature: _____ RDN Signature: _____