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Diabetes Self Management Program

Health Risk Assessment

Today's Date: _____

Name_____ Date of Birth _____

GENERAL INFORMATION

What is your race?

☐ American Indian or Alaskan Native	☐ Asian, Chinese, Japanese, Korean	☐ Black/African American	☐ Hispanic, Chicano, Latino, Mexican	☐ Middle Eastern
☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian	☐ Other	☐ Do not know	

What is your occupation? _____ Retired? ☐ Yes ☐ No

Describe your education:

☐ 8th grade or less ☐ Some high school ☐ High school graduate/GED
☐ Some college ☐ College degree (BA/BS) ☐ Graduate degree

What is your primary language? _____

Do you have difficult with:

☐ Physical difficulty ☐ Hearing ☐ Seeing ☐ Writing
☐ Reading ☐ English as a second language ☐ None of the above

Who do you live with?

☐ Alone ☐ With spouse/partner ☐ With spouse/partner and children
☐ With parents only ☐ With children only ☐ With other family members/friends

Who helps you with your diabetes?

☐ Self ☐ Spouse/partner ☐ Child
☐ Non-relative ☐ Other ☐ None of the above

Do you have financial resources to care for your diabetes? ☐ Yes ☐ No ☐ Do not know

Do you have emotional resources to care for your diabetes? ☐ Yes ☐ No ☐ Do not know

What do you feel are major stresses in your life?

How do you manage your stress?

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HEALTH STATUS:

What is your current height? _____ feet _____ inches

What is your current weight? _____ pounds

What is your current waist circumference? _____ inches ☐ Do not know

What are your most recent lab results?

A1c:	_____	Date test taken:	_____
Blood pressure:	_____	Date test taken:	_____
Total cholesterol:	_____	Date test taken:	_____
HDL:	_____	Date test taken:	_____
LDL:	_____	Date test taken:	_____
Triglycerides:	_____	Date test taken:	_____
Fasting Blood Glucose:	_____	Date test taken:	_____
Urine Protein:	_____	Date test taken:	_____

State your general feelings about your overall health:

In the past 12 months, have you had:

	How many times?	***What for?***
Hospital Admissions? ☐ Yes ☐ No		
Emergency Room Visits? ☐ Yes ☐ No		
Primary Care MD Visits? ☐ Yes ☐ No		
Specialist MD Visits? ☐ Yes ☐ No		
Eye Exam? ☐ Yes ☐ No		
Dental exam? ☐ Yes ☐ No		

Flu Vaccination? ☐ Yes ☐ No Date: _____

Pneumonia Vaccination? ☐ Yes ☐ No Date: _____

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DIABETES STATUS:

Have you had any previous diabetes education? ☐ Yes ☐ No ☐ Do not know

If Yes, date you received education: _____

Where did you receive education? _____

What type of diabetes do you have? ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Do not know

When were you diagnosed? Month: _____ Year: _____

Do you monitor your blood sugar? ☐ Yes ☐ No

If Yes, answer the following questions

How often? _____ times each ☐ Day or ☐ Week

What time of day do you normally check?

☐ before breakfast Average reading? _____ ☐ after breakfast Average reading? _____

☐ before lunch Average reading? _____ ☐ after lunch Average reading? _____

☐ before dinner Average reading? _____ ☐ after dinner Average reading? _____

☐ at bedtime Average reading? _____ ☐ other time(s) Average reading? _____

What meter are you using? _____

Do you perform a urine ketone test? ☐ Yes ☐ No

If yes, how often? _____

Have you had a recent episode of HIGH blood sugar? ☐ Yes ☐ No ☐ Do not know

If yes, what was your blood sugar value? _____

What symptoms did you have? _____

What actions did you take? _____

Have you had a recent episode of LOW blood sugar? ☐ Yes ☐ No ☐ Do not know

If yes, what was your blood sugar value? _____

What symptoms did you have? _____

What actions did you take? _____

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OTHER MEDICAL/SOCIAL HISTORY:

List any allergies you have: _____

Have you been diagnosed with:

Coronary artery disease:	☐ Yes	☐ No
Heart attack:	☐ Yes	☐ No
High blood pressure:	☐ Yes	☐ No
Stroke (CVA/TIA):	☐ Yes	☐ No
Peripheral vascular disease (poor leg circulation):	☐ Yes	☐ No
If yes, have you had an amputation?	☐ Yes	☐ No
Neuropathy (nerve damage):	☐ Yes	☐ No
Nephropathy (kidney damage):	☐ Yes	☐ No
If yes, are you currently on dialysis?	☐ Yes	☐ No
Have you had a kidney transplant?	☐ Yes	☐ No
Retinopathy (diabetes changes in the retina):	☐ Yes	☐ No
If yes, have you had laser treatment for this?	☐ Yes	☐ No
Do you have blindness from it?	☐ Yes	☐ No
Do you have cataracts?	☐ Yes	☐ No
Other issues?	☐ Yes	☐ No
High cholesterol:	☐ Yes	☐ No
Depression:	☐ Yes	☐ No

Other medical conditions not listed above:

Do you use tobacco? ☐ Yes ☐ No ☐ Quit

If yes, how much do you smoke: _____ packs per day

For how many years? _____

If you quit, how long ago? _____ years

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit

Do you drink regularly (a few times per week) or socially (a few times per month)?

☐ Regularly
☐ Socially

How much alcohol do you use? _____ drinks per week/month

If you quit, how long ago? _____

Do you examine your feet at least once a week? ☐ Yes ☐ No

Are you experiencing any sexual problems? ☐ Yes ☐ No

If yes, have you sought treatment for your sexual problems? ☐ Yes ☐ No

Was the treatment for your sexual problems successful? ☐ Yes ☐ No

For Women: **Number of Pregnancies:** _____ **# of Live Births:** _____ **History of gestational diabetes?** ☐ Yes ☐ No

Currently pregnant? ☐ Yes ☐ No

Contraceptive Method: _____

Planning to get pregnant? ☐ Yes ☐ No

Had a baby weighing 9 lbs or more? ☐ Yes ☐ No

Reached menopause? ☐ Yes ☐ No

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NUTRITION & EXERCISE:

Have you started eating differently since being diagnosed with diabetes? ☐ Yes ☐ No

If yes, what kinds of changes have you made?

☐ Eat less ☐ Eat less fat ☐ Eat less sugar
☐ Eat more vegetables ☐ Drink less soda/juices ☐ Other:

How many times a day do you eat?

☐ One ☐ Two ☐ Three ☐ Four or more

Which meals do you tend to skip?

☐ Breakfast ☐ Lunch ☐ Dinner

Who does the cooking in your house?

☐ Self ☐ Spouse ☐ Other

How many times per week do you eat out? _____

Do you have any special dietary needs? ☐ Yes ☐ No

Does your culture or religion require fasting or dietary restrictions? ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No

If yes, what type of exercise do you do?

☐ Walking ☐ Running ☐ Swimming ☐ Golfing
☐ Dancing ☐ Bike riding ☐ Tennis ☐ Aerobics
☐ Weight lifting/strength training ☐ Sports (basketball, softball, etc. ☐ Other

During a usual week, how many times do you exercise? _____

How long do you usually exercise? _____ minutes

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MEDICATIONS:

What medications do you currently take for diabetes?		
Name of Medicine	***Dose You Take***	***How Many Times a Day?***
☐ I don't take any medicine for my diabetes		

PERSONAL GOALS:

I hope to gain the following from this educational program?

List 2 things you feel you need the most help with to improve your diabetes:

1.
2.