Diabetes Hand On Assessment Form

Your diabetes educator has requested that you answer some questions about your diabetes in preparation for your education session. By answering these questions, you'll be providing valuable information to your diabetes care team. It's important that you answer as many questions as you can so your educator has a complete picture of your diabetes. It should only take you about 15 minutes to complete the questions.

Patient Information

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. Date_______________

First Name________________________ Middle Name ________________________
Last Name ________________________

Street Address ____
City________________________________ State _______________ Postal Code ___________

Work Phone ________________________ Home Phone _______________________
Cell Phone _________________________ Email ______________________________________

Primary Physician _________________________________ Phone ______________________
Address ____ Fax ________________________

Primary Insurance ________________________________ Phone ________________________
ID # ___________________________ Group # ___________________________
Secondary Insurance_______________________________ Phone ________________________

Demographics

Date of Birth ________________ ☐ Male ☐ Female

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

Occupation
☐ Clerical ☐ Homemaker ☐ Sales ☐ Professional/Managerial
☐ Skilled Labor ☐ Other labor ☐ Student ☐ Unemployed
☐ Retired ☐ Disabled ☐ Other ☐ Do Not Know

Preferred Language ☐ English ☐ Spanish ☐ Other ☐ Do not know

Education (highest level achieved)

☐ 8th Grade or less ☐ Some High School ☐ High School Graduate /GED
☐ Some College ☐ College Degree (BA/BS) ☐ Graduate Degree

Health Questions

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

2. What year were you diagnosed? ___________

3. Do you monitor your blood sugar? ☐ Yes ☐ No
   Frequency of blood sugar checks _________________ times per day
   Usual AM blood sugar value _________________
   Usual PM blood sugar value _________________
   Brand of monitor used _______________________________
   Model of monitor used ________________________________

4. Do you perform a Urine Ketone test? ☐ Yes ☐ No
   If Yes, how often do you perform a urine ketone test ? __________________________

5. Have you had a recent episode of high/low blood sugar?
   ☐ Yes ☐ No ☐ Don't know
   Frequency of episodes of high blood sugar ______________ Blood sugar value _______
   Frequency of episodes of low blood sugar ______________ Blood sugar value _______
   Blood sugar value _______
   Symptoms and action taken ____

6. Do you have difficulty with any of the following? ☐ Seeing ☐ Reading
   ☐ Physical difficulty ☐ Hearing ☐ Writing ☐ English as a second language
   ☐ None of the above

7. State your general feelings about your overall health ____________________________
   ____

8. Do you have chronic pain? ☐ Yes ☐ No **(If No, please go to question 15)**

9. Where do you have chronic pain? ____

10. Have you had treatment for your chronic pain? ☐ Yes ☐ No

11. List any allergies that you have ____

____

12. Have you ever been diagnosed with Depression? ☐ Yes ☐ No

13. Over the past two weeks, how often have you been bothered by any of the following problems? Please choose the appropriate response for each item:

Little interest or pleasure in doing things
☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

Feeling down, depressed or hopeless
☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

14. Have you been diagnosed with Coronary Artery Disease? ☐ Yes ☐ No

15. Have you ever suffered a Heart Attack? ☐ Yes ☐ No

16. Have you been diagnosed with High Cholesterol? ☐ Yes ☐ No

17. Have you been diagnosed with High Blood Pressure? ☐ Yes ☐ No

18. Have you ever suffered a Stroke/Transient Ischemic Attack? ☐ Yes ☐ No

19. Have you been diagnosed with Peripheral Vascular Disease (poor leg circulation)?
☐ Yes ☐ No If yes, have you had an amputation? ☐ Yes ☐ No

20. Have you been diagnosed with neuropathy (diabetes affecting the nerves)?
☐ Yes ☐ No

21. Is protein or albumin present in your urine? ☐ Yes ☐ No ☐ Don't know

22. Have you been diagnosed with Nephropathy (kidney disease)? ☐ Yes ☐ No
If yes, have you had a kidney transplant ? ☐ Yes ☐ No
Are you currently on dialysis? ☐ Yes ☐ No

23. Have you been diagnosed with Retinopathy (diabetes changed in retina)? ☐ Yes ☐ No
If yes, have you had any of the following?
Received laser treatments for diabetic problems ☐ Yes ☐ No
Do you have cataracts ☐ Yes ☐ No
Do you have blindness (in one or both eyes) ☐ Yes ☐ No
Other____

24. Have you had any falls in the past month? ☐ Yes ☐ No

25. Do you use tobacco? ☐ Yes ☐ No ☐ Quit **(If No, go to question 37)**
What type of tobacco do you use? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chew ☐ Snuff
How much tobacco do you use (packs, cans, cigars, etc. per day)? __________________
Did you ever go to counseling? ☐ Referred ☐ Refused ☐ Have you quit Date:______

26. Do you use alcohol? ☐ Yes ☐ No ☐ Quit
☐ Regularly (few times per week) or ☐ Socially (few times per month)?
How much alcohol do you use? _____(drinks per week) or _____ (drinks per month)

27. Who do you live with?____

28. Who helps you with your diabetes?
☐ Self ☐ Spouse ☐Child ☐ Non-Relative ☐ Other__________________

29. Do you have financial resources to care for your diabetes?
☐ Yes ☐ No ☐ Don't know

30. Do you have emotional resources to care for your diabetes?
☐ Yes ☐ No ☐ Don't know

31. What do you feel are major stresses in your life?______________________________
____

32. How do you manage your stress? ____
____

33. Do you feel unsafe or threatened at ☐ Home ☐ Work ☐ School (Please choose all that apply)

34. Rate how safe you feel. Please choose the appropriate response for each item:

Not safe	2	3	4	5	6	7	8	9	Very safe
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

35. Have you had any previous diabetes education? ☐ Yes ☐ No ☐ Don't know
If Yes, date you received your diabetes education? Month_______ Day ____Year_____
Where did you receive your diabetes education? ______________________________

36. In the past 12 months, have you had a Hospital Admission? ☐ Yes ☐ No
Approximate number of hospital admissions in past 12 months? _________
Total number of days in the hospital last year? ________

Reason(s) for hospital admissions ____

37. In the past 12 months, have you had an emergency room visit? ☐ Yes ☐ No
Approximate number of emergency room visits in past 12 months? ______________
Reason for emergency room visits____

38. In the past 12 months, have you had a primary care physician visit? ☐ Yes ☐ No
Approximate number of primary care physician visits in past 12 months? __________
Reason for primary care physician visits_____________________________________

39. In the past 12 months, have you had other specialist visits? ☐ Yes ☐ No
Approximate number of specialists visits in past 12 months?____________
Reason for specialist visits____

40. Are you eating differently since you found out you have diabetes?
☐ Yes ☐ No ☐ Don't know
If yes, what type of changes have you made?
☐ Eat Less ☐ Eat More Vegetables ☐ Eat Less Sugar
☐ Eat Less Fat ☐ Drink Less Pop, Juice
Other ____

41. How many times per day do you eat?
☐ One ☐ Two ☐ Three ☐ Four or more

42. Which meals do you tend to skip? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ None

43. Who does the cooking in your house?
☐ Self ☐ Spouse ☐ Other_________________________________

44. How often do you eat out? ____

45. Do you have any special dietary needs? ☐ Yes ☐ No
____

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

47. Do you exercise? ☐ Yes ☐ No

What type of exercise do you do?

☐ Walking	☐ Bike riding	☐ Sports (basketball, softball, etc.)
☐ Running	☐ Golfing	☐ Aerobics
☐ Swimming	☐ Tennis	☐ Weight lifting/ Strength training
☐ Dancing	☐ None	☐ Other ______________________

How many days do you exercise? __________________________________

How many minutes do you usually exercise? _________________________

48. How often do you examine your feet? Please choose **only one** of the following:

☐ Daily	☐ Once a month
☐ Few times a week	☐ Less than once a month
☐ Once a week	☐ Never
☐ Few times a month	

49. I hope to gain the following from this educational program: _____________________

____

____

50. List two things you feel you need the most help with to improve your diabetes:

1. ____
2. ____

51. During the last year did you ever worry whether the food in the house would run out before there was money to get more?____

52. Sometime people run out of the food they need to take care of their diabetes and don't have enough money or resources to get more. In the last 30 days, how often did you run out of food you needed to take care of your diabetes? ____________________________

Thank you for completing your self –report. The information you supplied will provide your diabetes care team with a better picture of your diabetes.

ACKOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Diabetes Hands On Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by Diabetes Hands On and how I may obtain access to and control this information.

____

Signature of Patient or Personal Representative

____

Printed Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative’s Authority

PHOTO PERSONAL RELEASE

I give permission to the Coastal Bend Food Bank Inc., to record, photograph, film, tape or otherwise capture my name, likeness, voice, actions and biography (collectively, "Likeness"), and to use, and to authorize others to use, my Likeness, forever throughout the world. The Coastal Bend Food Bank Inc. may use my Likeness in print, television, radio, film, internet and in all other media now known or hereafter existing for external and internal communications, including without limitation, publicity and promotion.

I waive the right to inspect or approve such use of my Likeness. Coastal Bend Food Bank will be under no obligation to actually use my Likeness. I have received no consideration for this personal release, and no l compensation is due to me.

I release the Coastal Bend Food Bank Inc., its officers, directors, agents and employees from all claims and liabilities of any kind arising out of or in connection with the making or use of my Likeness, including without limitation, claims based upon invasion of privacy, defamation, or right of publicity.

____
Signature

____
Print Name

____
Address

____
Date

If subject is under 18 years old:

Parent's or guardian's name (please print)_________________________________

Parent's or guardian's signature____

Your relationship to the child(children)___________________________________

Class Attendance Memorandum

Due to the limited class size set up, please understand you are committing to an 8-week class series and are expected to be available to come for the entire series (8 classes). You may miss up to 2 classes and still graduate to receive on-going support and we encourage you to do so. We understand situations may arise and therefore ask you contact us if you need to miss a day for an accurate meal count, or cannot continue the series to enroll another person on the waiting list.

By signing you acknowledge you have read this statement.

____

Signature   Date

Text Messaging

Diabetes Hands On can text class reminders to your phone if you choose. You will only be contacted for class reminders <u>one time a week</u> for the 8 week duration. You may opt out later if you choose.

Please check the appropriate box:

- ☐ Yes, please send me text reminders (Phone Number)____________________
- ☐ No, I would not like text reminders

Name____________________

Diabetes Knowledge Questionnaire (Pre)

1) What can a person do to prevent diabetes complications?
   a) Stop smoking
   b) Exercise
   c) Monitor their blood glucose
   d) All of the above
   e) Don't know

2) Record **all** carbohydrate foods that would be considered 1 carbohydrate serving (15 grams of carbohydrate).
   a) 3 ounces chicken
   b) ½ cup green beans
   c) ½ cup mashed potatoes
   d) 1 tsp. butter
   e) 1 oz. dinner roll

3) Which of these foods is in the fat group?
   a) Steak
   b) Brownie
   c) Milk
   d) Peanuts
   e) Don't know

4) One of insulin's functions is to help the glucose enter into the cells of the body.
   a) True
   b) False

5) What is the best action to prevent diabetes?
   a) Drink unsweetened fruit juice
   b) Lose weight
   c) Limit meat
   d) Get more sleep
   e) Don't know

6) People who have Type 1 diabetes must
   a) Take daily injections of insulin.
   b) See their doctor every month.
   c) Only eat meat.
   d) Don't know

7) Record **<u>all</u>** the risk factors for diabetes.
   a) Family history
   b) Being overweight/ obesity
   c) Regular exercise
   d) Past gestational diabetes
   e) Stress

8) Which of these foods is a protein food?
   a) Whole grain bread
   b) Fish
   c) Olives
   d) Green peppers

9) One of the jobs of the pancreas is to make glucose.
   a) True
   b) False

10) Regular exercise will **<u>not</u>**...
   a) Lower good cholesterol levels
   b) Lower bad cholesterol levels
   c) Lower stress levels
   d) Lower blood pressure
   e) Don't know

11) What is the recommended fasting blood glucose level for someone with diabetes?
   a) 50-80 mg/dl
   b) 40-70 mg/dl
   c) 130-150 mg/dl
   d) 80-130 mg/dl
   e) Don't know

12) Which of the following statements best describes Type 2 diabetes?
   a) It can be cured
   b) It is an infectious disease
   c) It is a disease of the immune system
   d) It is a chronic disease
   e) Don't know

13) How often should people with diabetes check their feet for sores, changes, or signs of infection?
   a) Once a week
   b) Every day
   c) Every month
   d) Twice a month
   e) Don't know

14) What is the recommended Hemoglobin A1c range for a person with diabetes to prevent complications?
   a) Less than 4.0
   b) Less than 7.0
   c) Less than 10.0
   d) Less than 12.0
   e) Don't know

15) What do carbohydrates become in the body?
   a) Glucose
   b) Bones
   c) Acid
   d) Muscles
   e) Don’t know

16) What yearly vaccination is recommended for persons with diabetes?
   a) Measles
   b) Hepatitis A
   c) Polio
   d) Flu
   e) Don't know

17) The Hemoglobin A1c test checks for ...
   a) Cholesterol levels
   b) Average Blood Glucose
   c) Average Blood Pressure
   d) Microablbumin

18) Diabetes is the leading cause of what condition in the United States?
   a) Alzheimer's Disease
   b) Arthritis
   c) Adult Onset Blindness
   d) Cancer
   e) Don't know

19) How often should a person with diabetes have their eyes checked by an eye doctor?
   a) Every three months
   b) Once a year
   c) Twice a year
   d) Every two years
   e) Don't know

20) You should have your kidneys checked one time a year.
   a) True
   b) False

21) Which of the following is a carbohydrate food?
   a) Chicken
   b) Cheese
   c) Apple
   d) Celery
   e) Don't know

22) A moderate amount of alcohol intake is considered 2 drinks per day for women and 3 drinks per day for men.
   a) True
   b) False

23) Hemoglobin A1c reflects the average blood glucose level over what period of time?
a) 24 hours
b) 2 hours
c) 3 months
d) 8 weeks
e) Don't know

24) Which of the following is a common complication of diabetes?
a) Arthritis
b) Kidney disease
c) Hearing loss
d) Migraine headaches
e) Don't know

25) You should brush your teeth at least two times a day.
a) True
b) False

26) Laura is sick, has nausea and vomiting, and cannot eat. Which of the following liquids does **not** contain carbohydrate?
a) Chicken bouillon
b) Apple juice
c) 7-Up
d) Gatorade
e) Don't know

27) It is safe to exercise when your blood glucose is 300 mg/dl.
a) True
b) False

Write "High" or "Low" in the spaces for the following actions.

High = Blood Glucose Increases
Low = Blood Glucose Decreases

28) ________ Get sick
29) ________ Skip a meal
30) ________ Do not take diabetes medicine
31) ________ Mow the grass
32) ________ Eat a candy bar with two regular sodas

33) A 12 ounce can of beer is equal to one alcoholic drink.
 a) True
 b) False

34) Which things below that effect blood glucose levels.
 a) stress
 b) food
 c) medication/insulin
 d) activity
 e) all of the above