

**JOHNS HOPKINS DIABETES EDUCATION PROGRAM**  
**DIABETES SELF-MANAGEMENT ASSESSMENT**

Date: \_\_\_\_\_

JHH # \_\_\_\_\_

**I. General Information**

Name: \_\_\_\_\_ Marital Status:  M  S  W  SEP  D

Address: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Email: \_\_\_\_\_ Fax: \_\_\_\_\_

Sex:  M  F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Goal Weight: \_\_\_\_\_

Occupation: \_\_\_\_\_ Last grade in school completed: \_\_\_\_\_

**II. Health Problems Other Than Diabetes:**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eye disease          | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Nerve disease        | _____                                 |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Foot problems        | _____                                 |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Liver disease        |                                       |
| <input type="checkbox"/> Thyroid             | <input type="checkbox"/> Circulation problems |                                       |
| <input type="checkbox"/> Stomach/Ulcers      | <input type="checkbox"/> Arthritis            |                                       |
| <input type="checkbox"/> Kidney/Bladder      | <input type="checkbox"/> Skin problems        |                                       |
|  | <input type="checkbox"/> High Cholesterol     |                                       |

Do you inspect your feet?  Y  N How often? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date Diabetes Diagnosed: \_\_\_\_\_ Medications for Diabetes: \_\_\_\_\_

Medications for High Blood Pressure: \_\_\_\_\_

Medications for Cholesterol: \_\_\_\_\_

Last Seen By Dietitian: \_\_\_\_\_ Last seen by Diabetes Educator: \_\_\_\_\_

**III. Exercise/Activity**

Do you have a regular exercise routine?  Y  N

What are your limitations to exercise: \_\_\_\_\_

TYPE OF EXERCISE	NUMBER OF TIMES A WEEK	LENGTH OF TIME SPENT

Describe your daily activity level:

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- Sedentary (sit most of day)       Moderate (on feet most of day)  
 Light (desk work)                       Heavy (manual labor)

**IV. Eating Habits**

Do you follow a meal plan?  Y  N Calorie level? \_\_\_\_\_ Carbohydrate Grams? \_\_\_\_\_

Who shops for food? \_\_\_\_\_ Who cooks? \_\_\_\_\_

Do you or the shopper read food labels?  Y  N What do you look for? \_\_\_\_\_

Do you have any food allergies: \_\_\_\_\_

**FLUIDS:** Usual amounts taken daily or as specified – by ounces, cans, jiggers, etc.

Water: \_\_\_\_\_ Milk: \_\_\_\_\_ kind: \_\_\_\_\_ Fruit Juice: \_\_\_\_\_ Sodas: Reg. \_\_\_\_\_ Diet \_\_\_\_\_

Coffee: \_\_\_\_\_ with: \_\_\_\_\_ Tea: \_\_\_\_\_ with: \_\_\_\_\_ Beer: \_\_\_\_\_ daily: \_\_\_\_\_ weekend: \_\_\_\_\_

Wine: \_\_\_\_\_ daily: \_\_\_\_\_ weekend: \_\_\_\_\_ Whiskey: \_\_\_\_\_ daily: \_\_\_\_\_ per week \_\_\_\_\_ weekend \_\_\_\_\_

Please list the meals and snacks you usually eat below. Please note the time of day for meals and snacks and the food eaten, i.e., medium baked potato, fried chicken, broiled steak, broccoli, corn, banana, desserts, beverages, etc. If possible, note the approximate serving size of each food.

TYPICAL MEAL PATTERN	
TIME/PLACE	USUAL INTAKE
<b>BREAKFAST:</b>	
<b>LUNCH:</b>	
<b>DINNER:</b>	

SNACKS	
TIME/PLACE	USUAL INTAKE

Are you able to follow a meal plan no matter where you eat?  Yes  No  Sometimes

MEALS EATEN AWAY FROM HOME		
MEAL	TYPE OF PLACE	HOW MANY TIMES/WEEK
Breakfast		
Lunch		
Dinner		

### V. MONITORING

Do you monitor your blood sugar?  Yes  No  Sometimes

What monitor do you use?	
How often do you test?	Do you keep a record? ? <input type="checkbox"/> Yes <input type="checkbox"/> No
Usual blood glucose results?	

### VI. MEDICATION

Do you take medication for your diabetes?  Yes  No

What diabetes medication do you take?	
Have you ever forgotten to take your diabetes medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What did you do?	
If you take insulin, do you inject with: <input type="checkbox"/> a syringe <input type="checkbox"/> an insulin pen <input type="checkbox"/> insulin pump	
Who fills the syringes?	Who gives the injection:
What injection site do you use?	
Where do you keep your insulin?	
Where do you dispose of your syringes?	Do you reuse your syringes? <input type="checkbox"/> Yes <input type="checkbox"/> No

### VII. ACUTE COMPLICATIONS

Have you ever had a low blood sugar reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know	
If yes, how did you feel?	
How did you treat it?	
Do you carry a source of sugar with you? <input type="checkbox"/> Yes, _____ <input type="checkbox"/> No	
Have you ever had a high blood sugar reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Do not know	
If yes, how did you feel?	
How did you treat it?	
What do you consider is a normal blood glucose range?	

**VIII. CHRONIC COMPLICATIONS**

Are you aware of the complications that may develop when you have diabetes?  Yes  No

**IX. MEDICAL HISTORY INFORMATION**

When was your last exam:

Dilated eye exam:	Dental exam:	Pneumonia shot:
Podiatrist foot exam:	Flu shot:	Physical exam:

- Does anyone in your family have diabetes?  Yes  No  
If yes, please list: \_\_\_\_\_
- Have you noticed any changes in your skin recently?  Yes  No  
If yes, please describe: \_\_\_\_\_
- Have you been in the emergency room in the last 6 months?  Yes  No  
If yes, explain: \_\_\_\_\_
- Have you been admitted to the hospital in the last 6 months?  Yes  No  
If yes, explain: \_\_\_\_\_
- How would you describe your general health:  Excellent  Good  Fair  Poor
- Is your health important to you?  All the time  Sometimes  Only when ill  Not at all

7. Tobacco/Alcohol/Drug history of use:		
Tobacco: <input type="checkbox"/> never <input type="checkbox"/> cigarettes <input type="checkbox"/> cigar <input type="checkbox"/> snuff If use, how many years? _____, quantity used? _____  If quit, when? _____ How many years did you use? _____ <b>We DO recommend a smoking cessation class.</b>	Alcohol: <input type="checkbox"/> never <input type="checkbox"/> special occasions  Circle appropriate number of alcohol beverages: Occasionally 1 - 3 drinks/week 4 - 10 drinks/week 11 or more drinks/week	Illicit Drugs:

**X. STRESS**

- Is there much stress in your life?  Yes  No  
If yes, explain: \_\_\_\_\_
- What do you do to handle/manage stress in your life? \_\_\_\_\_

**XI. PREGNANCY (women only)**

- Are you currently pregnant?  Yes  No If yes, due date: \_\_\_\_\_

2. Are you planning to become pregnant?  Yes  No
3. Have you ever been pregnant?  Yes  No If yes, how many times: \_\_\_\_\_  
 Was any birth weights 9 pound or more?  Yes  No  
 How many children are living? \_\_\_\_\_
4. Are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes?  Yes  No
5. Do you use a method of birth control do you use?  
 No  Yes If yes, what do you use? \_\_\_\_\_

**XII. MEDICATION SUMMARY**

Please complete the chart below.

List medications, vitamins, minerals, or herbal supplements you are taking: (Diabetes meds first, then other medications, and supplements last)	Amount you take or dose:	Time medication is taken:	Comments: Do you need refills?	Changes: (Initial & Date)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

**Medication Allergies** (please include all): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**XIII. EDUCATIONAL NEEDS**

What areas of diabetes would you like more information or help with: \_\_\_\_\_  
 \_\_\_\_\_

*Patient Signature and Date Completed:*

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\*\*\*\*\* THE FOLLOWING IS TO BE COMPLETED BY THE DIABETES CENTER STAFF: \*\*\*\*\*

<input type="checkbox"/> Diabetes disease process	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> MNT	<input type="checkbox"/> Chronic complications
<input type="checkbox"/> Physical activity	<input type="checkbox"/> Goal setting and problem solving
<input type="checkbox"/> Medications	<input type="checkbox"/> Psychological adjustment
<input type="checkbox"/> Monitoring	<input type="checkbox"/> Preconception care, pregnancy, GDM

**Staff Signature and Date Completed:**