

**LIVING SMART DIABETES SELF MANAGEMENT PROGRAM  
INITIAL HEALTH ASSESSMENT**

**1. Demographics**

Patient Name: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
Who is your Primary care doctor?  Dr. \_\_\_\_\_  
How did you hear of our program?  Dr. Hanson  Primary MD  Ad  friend  
If Ad, which one? \_\_\_\_\_

Primary Language spoken:  English  Spanish  French  Other \_\_\_\_\_  
Barriers to Learning:  Poor vision  Hearing loss  Poor memory  
 problem understanding  difficulty reading  speak English poorly  
Cultural factors: \_\_\_\_\_ Religious Influences: \_\_\_\_\_  
Sex:  Male  Female  Single  Divorced  Married  Widowed  
Race:  Caucasian  Black  Hispanic  Asian  Afro American  other

Employed:  Yes  No Retired:  Yes  No  
Name of current employer \_\_\_\_\_  
Do you live with anyone?  Yes  No How many people in family? 2 3 4 5 6  
Does anyone in your family have diabetes?  Yes  No If yes, who? \_\_\_\_\_  
High school level: Circle one 1 2 3 4 5 6 7 8 9 10 11 12 College level? \_\_\_\_ Vo-Tech? \_\_\_\_  
Readiness to learn: check one  eager  willing to learn  not willing to learn

**2. Medical History ( please check all your health problems from list below )**

High blood pressure  Heart Disease  Stroke  
 Burning or numbness / tingling in hands or feet  
 Eye problems from diabetes  Kidney problems from diabetes  
 High cholesterol or Triglycerides  Problem with sexual function  
 Back pain / Arthritis  Digestion problems  NO PROBLEMS

**Diabetes History**

Type 1  Type 2 on pills  Type 2 on insulin  Type 2 on diet  pump

• Your age when diagnosed with diabetes: \_\_\_\_\_ years old

• Home monitoring: Name of glucose meter \_\_\_\_\_

How many times a day do you test your blood sugar? circle one 0 1 2 3 4 5+

• Do you keep a record?  Yes  No Do you test daily  Yes  No

• Do you ever test your blood sugar 2 hours after eating?  Yes  No

Have you been hospitalized or had to call EMS because of high or low blood sugar reading in the past year?  Yes  No

How would you treat a low blood sugar reaction? \_\_\_\_\_

Name of Diabetes meds / Insulin \_\_\_\_\_ How taken \_\_\_\_\_

**3. Physical activity habits:**

Activity:  Walk  Swim  Bike  Jog  Aerobics  gym  
Other:  Yard work  \_\_\_\_\_  
Time of day you do activity: \_\_\_\_\_  
Duration:  15 mins or less  20-30 mins  30-60 mins  over 60 minutes

If you are not active, please explain why? \_\_\_\_\_

**4. Self Care Behaviors**

Have you seen the eye doctor in the past year?  Yes  No  
Do you inspect your feet daily?  Yes  No If no, why not? \_\_\_\_\_

Have you seen the foot doctor in the past year?  Yes  No  
Do you go barefoot?  Yes  No Prosthetic Device used?  Yes  No  
Do you smoke?  Yes  No  Quit When? \_\_\_\_\_  
Do you drink Alcohol?  Yes  No  Quit When? \_\_\_\_\_  
Have you seen the dentist in the past year?  Yes  No

Do you take your medication as prescribed by your doctor?  Yes  No  
Do you attend a diabetes support group?  Yes  No Why not? \_\_\_\_\_  
Do you use diabetes identification?  Yes  No Type? \_\_\_\_\_

**WHEN YOU ARE SICK,**  
Do you take your diabetes meds?  Yes  No If no, why not? \_\_\_\_\_  
Do you test your blood sugar more frequently?  Yes  No If yes, how often? \_\_\_\_\_  
When ill, what might you replace solid foods with? \_\_\_\_\_

**PSYCHOSOCIAL HISTORY:** Support person: \_\_\_\_\_

Stress level: 1-10 (10 being greatest) \_\_\_\_\_ - Cause: \_\_\_\_\_  
What do you do when you feel stressed? \_\_\_\_\_  
How much does diabetes affect your daily activities? \_\_\_\_\_  
Has having diabetes affected your relationship with friends and family? If yes, how? \_\_\_\_\_

**6. PLEASE CHECK YOUR GOALS OR AREAS YOU WOULD LIKE TO LEARN**

Blood glucose monitoring  Meal planning  Hygiene/ foot care instruction  
 Diabetes medication management  exercise management  Stress reduction  
 Complications prevention  low blood sugar knowledge  All areas  
 high blood sugar knowledge  Other \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Educator Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_