dayton children's

Self-Assessment of Diabetes Management

Please answer these questions to the best of your ability. This helps us to tailor any education/review done today to fit your needs. Please circle your answers ("yes", "no", etc.) where it applies.

Patient's name _____ Date of Birth _____

1) What type of diabetes do you have? Type 1 / Type 2 / Pre-diabetes / Other: _____
2) In your own words, what is diabetes?
   _____
3) How do you control your diabetes? (circle any that apply)
   Exercise Diet/meal plan Insulin Pills Injection other than insulin
4) Nutrition:
   - Do you count carbohydrates (carbs) Yes / No
     If no, would you like to learn how to count carbs? Yes / No
   - Do you use food labels as a guide? Yes / No
   - What **time** do you typically eat? Breakfast _____ Lunch _____ Dinner _____ Snacks _____
   - Give a sample of a meal for a typical day, can put # of carbs if you count carbs
     Meal: _____
5) How often do you check blood sugars? _____ times each day (can put range)
   - What is your **target** blood sugar? _____
   - Do you know how to send blood sugars to the diabetes team to be reviewed? Yes / No
6) *What diabetes medication/insulin do you take and how often do you take it?*
   - Name _____ When given _____
   - Name _____ When given _____
   - Name _____ When given _____
   - Name _____ When given _____
   - Name _____ When given _____
   - What do you do if you miss a dose? _____
   - Do you take your medication before you eat or after you eat? Before / After
7) High blood sugars:
   - Can you tell when your blood sugar is too high? Yes / No
   - What do you do to lower your blood sugar?
     _____
8) Do you check ketones? Yes / No ***If yes, answer the following questions. If no, skip to #9***
   - When do you check ketones? _____
   - What do you do if you have ketones? _____
9) Are you on insulin or a medication that can cause low blood sugars? ***If yes, answer the following questions. If no, skip to #10.***
   - Can you tell when your blood sugar is too low? Yes / No
   - *What do you do to raise your blood sugar?* _____
   - What can other people do to help if your blood sugar drops so low that you pass out?
     _____

10) Do you exercise? Yes / No

- *If yes, what do you do? _____ How often? _____*
- What effect does exercise have on your blood sugar? Raises / Lowers / No Effect
    - If it lowers it, how do you avoid lows with exercise?

_____

11) Have you had any of the following complications? (circle) ***If none apply, skip to # 12***

Passed out or had seizure from low blood sugar	DKA (Diabetic Ketoacidosis	Eye problems	Teeth/gum problems
Depression	Kidney problems	Numbness/tingling/loss of feeling in feet	Sexual problems
High cholesterol	High blood pressure	Other:	

12) Do you see your eye doctor, dentist, and primary care physician regularly? Yes / No
Please describe:

_____

13) What is the hardest thing for you in caring for your diabetes?

_____

14) What concerns you most about your diabetes?

_____

15) What helps you to manage your stress?

_____

16) Who helps you in caring for your diabetes?
Family / Friends / Teachers / School nurse / Doctors / No one /
Other:_____

17) What is your goal A1C? _____

18) What diabetes topics would you like to discuss today?

_____

This section is to be completed by the diabetes nurse:

Education Needs/Plan:

- ☐ Diabetes Pathophysiology & Concepts of Management
- ☐ Carbohydrate counting & healthy eating
- ☐ Physical activity
- ☐ Medication management
- ☐ Glucose monitoring & use of patient-generated health data
- ☐ Preventing acute complications
- ☐ Preventing chronic complications
- ☐ Healthy coping & living well with diabetes
- ☐ Problem solving

Diabetes nurse signature: _____ Date: _____