Positive Patterns for Life
Diabetes Health Questionnaire

Please answer as many of the following questions as you can. The answers to these questions provide valuable information which will help me learn how I can best help you achieve your health goals. It should only take you about 15 minutes to complete the questions.

Patient Information

First Name_____ Last Name _____

Street Address _____

City_____ State _____ Zip _____

Phone _____ Email _____

Demographics

Date of Birth _____ Age _____ ☐ Male ☐ Female

Race
- ☐ American Indian or Alaskan Native
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Middle Eastern
- ☐ Asian/Chinese/Japanese/Korean
- ☐ Hispanic/Chicano/Latino/Mexican
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____

Occupation _____

Education (highest level achieved) _____

Questions about Diabetes Self-Management Education

Have you had any previous diabetes self-management education? ☐ No ☐ Yes, in (year) _____

What format? ☐ One-on-one ☐ Group classes How many sessions/classes? _____

List two things you feel you need the most help with to manage diabetes and improve your health:

1. _____
2. _____

☐ I have indicated content areas and topics that I would like included in my Diabetes Self-Management Education Plan by completing the *Diabetes Self-Management Topics of Interest Form*.

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? ☐ No ☐ Yes, _____ time(s) per day – check all that apply:
   ☐ Fasting (before breakfast) blood sugar readings run from _____ to _____
   ☐ Before lunch blood sugar readings run from _____ to _____
   ☐ Two hours after lunch blood sugar readings run from _____ to _____
   ☐ Before super blood sugar readings run from _____ to _____
   ☐ Before bed blood sugar readings run from _____ to _____

4. Have you had a recent episode of high blood sugar? ☐ No ☐ Don't know ☐ Yes, explain:
   Frequency of episodes of high blood sugar _____
   Blood sugar readings (how high) _____
   Symptoms and action taken _____
   _____

5. Have you had a recent episode of low blood sugar? ☐ No ☐ Don't know ☐ Yes, explain:
   Frequency of episodes of low blood sugar _____
   Blood sugar readings (how low) _____
   Symptoms and action taken _____
   _____

6. Do any of the following things prevent you from taking care of yourself?
   ☐ Lack of insurance ☐ Lack of Transportation ☐ Poor mobility
   ☐ Lack of money ☐ Depression or Anxiety ☐ Other _____
   ☐ Lack access to food ☐ Lack of Emotional Support ☐ None of the above

7. Do you have difficulty with any of the following? ☐ Seeing ☐ Hearing ☐ Reading
   ☐ Physical difficulty ☐ Writing ☐ None of the above

8. State your general feelings about your overall health _____
   _____

9. Do you have chronic pain? ☐ Yes ☐ No - skip to question 14

10. Where do you have chronic pain? _____

11. How long have you had chronic pain? ☐ Weeks ☐ Months ☐ Years

12. Have you had treatment for your chronic pain? ☐ No ☐ Yes – please describe your treatment:
    _____

13. Rate your pain on the 1 to 10 scale below:
☐ Slight (1) ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ Severe (10)

14. Have you had any falls in the past month? ☐ No ☐ Yes, explain _____
_____

15. List any allergies that you have _____
_____

16. Have you ever been diagnosed with Depression? ☐ No ☐ Yes, please explain _____
_____

17. Have you been diagnosed with Coronary Artery Disease? ☐ No ☐ Yes, when _____

18. Have you ever suffered a Heart Attack? ☐ No ☐ Yes, when _____

19. Do you have a cardiologist? ☐ No ☐ Yes, last appointment was _____

20. Have you been diagnosed with High Cholesterol? ☐ No ☐ Yes, explain treatment _____
_____

21. Have you been diagnosed with High Blood Pressure? ☐ No ☐ Yes, explain treatment _____
_____

22. Have you ever suffered a Stroke/Transient Ischemic Attack? ☐ No ☐ Yes, when _____

23. Have you been diagnosed with Peripheral Vascular Disease (poor leg circulation)? ☐ No ☐ Yes:
When? _____ Have you had an amputation? ☐ No ☐ Yes, when _____

24. Do you look at (examine) all surfaces of your feet every day? ☐ No ☐ Yes

25. When was your last diabetes foot exam? Month/Year_____ Was it normal? ☐ Yes ☐ No

26. Have you been diagnosed with neuropathy (diabetes affecting the nerves)? ☐ No ☐ Yes, explain:
When? _____ Symptoms? _____

27. Is protein or albumin present in your urine? ☐ No ☐ Don't know ☐ Yes, when _____

28. Have you been diagnosed with Nephropathy (kidney disease)? ☐ No ☐ Yes, answer the following:
If Did your doctor or nephrologist recommend any of the following (check all that apply):
☐ Limit protein intake ☐ Take ARB or ACE inhibitor ☐ Limit fluid intake ☐ Dialysis
☐ Avoid NSAIDs ☐ Limit phosphorous intake ☐ Limit Salt Intake ☐ Kidney transplant
☐ Other – please explain _____

29. Do you have a nephologist? ☐ No ☐ Yes, last appointment was _____

30. Have you been diagnosed with conditions that affect vision (check all that apply):
- ☐ Cataracts – surgery? ❍ No ❍ Yes, when _____
- ☐ Macular degeneration – treatment? ❍ No ❍ Yes, explain _____
- ☐ Macular edema – treatment? ❍ No ❍ Yes ___Intravitreous injections ___Surgery
- ☐ Glaucoma – treatment? ❍ No ❍ Yes ___Medication ___Surgery
- ☐ Retinopathy – treatment? ❍ No ❍ Yes ___Retinal laser treatments ___Intravitreous injections
- ☐ Blindness, which eye(s)? ___Right eye ___Left eye
- ☐ Other, explain _____

31. Do you have an eye doctor? ☐ No ☐ Yes, last appointment was _____

32. Do you have any other medical conditions? ☐ No ☐ Yes, explain _____
_____

33. Do you use tobacco? ☐ No ☐ Yes, how much? _____

34. Do you use alcohol? ☐ No ☐ Yes, how much? _____

35. Who do you live with? ☐ Live alone ☐ With spouse or partner
☐ With children only ☐ With parents only ☐ With spouse/partner and children
☐ With other family members or friends ☐ Other _____

36. Who helps you with your diabetes? _____

37. What do you feel are major stresses in your life?_____
_____

38. How do you manage your stress? _____
_____

39. Do you have regular meal times? ☐ Yes ☐ No

40. Which meals do you tend to skip? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Don't skip meals

41. Do you snack between meals? ☐ No ☐ Yes, I eat _____ snacks per day

42. Who does the cooking in your house? ☐ Self ☐ Spouse/Partner ☐ Other_____

43. Do you eat at restaurants at least 1 time per week? ☐ No ☐ Yes, _____ per week at the following types of restaurants _____

44. Do you have any special dietary needs? ☐ No ☐ Yes, explain _____
_____

45. Do you have any dental issues? ☐ No ☐ Yes – circle all apply: missing teeth / untreated cavities / dentures / tooth pain / loose teeth / gingivitis / other _____

46. Do you brush your teeth daily? ☐ Yes ☐ No Floss or pick daily? ☐ Yes ☐ No

47. When was your last dental exam? Month/Year _____ Was it normal? ☐ Yes ☐ No

48. Fill in the blanks below to provide an overview of your nutritional intake. Items in brackets [ ] indicate that you should circle what applies to your eating habits.

I eat dairy products [milk / yogurt /cheese / cottage cheese] ____ times per [day / week] – list examples _____

_____

I eat vegetables [non-starchy / raw / starchy / beans] _____ times per [day / week] – list examples _____

_____

I eat fruit _____ times per [day / week] – list examples _____

I eat protein [meat / game / fish / seafood / eggs / nuts] _____ times per [day / week] – list examples _____

_____

I eat grain products [cereal / bread / pasta / crackers / rice] _____ times per [day / week] – list examples _____

_____

I drink caffeine-free, sugar-free beverages [water / green tea / decaf coffee] _____ ounces per [day / week] – list examples _____

I drink sugary beverages [soda pop / fruit juice / sports drinks] _____ times per [day / week] – list examples _____

_____

I eat sweets [candy / chocolate / cookies / pastries / ice cream] _____ times per [day / week] – list examples _____

_____

I eat junk food [potato chips / Cheetos / roman noodles] _____ times per [day / week] – list examples _____

_____

I add fat to my food/drinks [cream / butter / creamy dressings / sour cream / oil] _____ times per [day / week] – list examples _____

49. Do you experience food cravings? ☐ No ☐ Yes, explain _____

_____

50. Is there anything unhealthy about your diet? ☐ No ☐ Yes, explain _____

_____

51. Please complete the following statements about your physical activity:

I have a structured exercise program: ☐ No ☐ Yes – explain how much (i.e. minutes per day/week) and list types of structured exercise _____

_____

I perform muscle toning/strengthening exercises weekly: ☐ No ☐ Yes – explain how much and list types of strengthening/toning exercises _____

I perform stretching exercises: ☐ No ☐ Yes – explain how much (i.e. minutes per day/week) and list types of exercise _____

I am up on my feet, moving about _____ number of hours most days (not including structured exercise).

I sit _____ number of hours most days.

52. Do you get at least 7 hours of quality sleep most nights? ☐ Yes ☐ No, explain _____
_____

53. When was your last diabetes exam with labs? Month/Year _____

54. What is your most recent A1c level? _____ When? Month/Year _____

55. What is your height? _____ft. _____in. Weight? _____lbs. Waist circumference? _____in.

56. Have you ever had to go to the emergency room because of your diabetes or a diabetes related complication? ☐ No ☐ Yes, explain _____

57. Have you ever been hospitalized because of your diabetes or a diabetes related complication? ☐ No ☐ Yes, explain _____

Prescription Medications

MEDICATION NAME	DOSE/FREQUENCY	TREATS WHAT CONDITION

Over-the-Counter Medications

MEDICATION NAME	DOSE/FREQUENCY	TREATS WHAT CONDITION

Supplements

NAME OF SUPPLEMENT	DOSE/FREQUENCY	TREATS WHAT CONDITION