



DIABETES HISTORY

Name: _____

Date: _____

1. How long have you known you have diabetes? _____

2. Do you have any of the following health problems? (if yes, please check)

- Heart Disease, Kidney problems, Heart failure, Foot problems, Arthritis, High cholesterol, High blood pressure, Numbness of hands, feet, or legs, Eye or vision problems, Gastrointestinal problems, Stroke

3. If working, what are your work hours? _____

4. Do you practice any cultural traditions that may interfere with your diabetes self-care? Yes No

5. Do you have at least 1 person to support you in your diabetes self-care? Yes No

6. Do you drink alcohol? Yes No

7. Do you use tobacco? Yes No

8. Have you been following any type of diabetes food plan? Yes No

9. If yes, what type or food plan have you been using? _____

10. Do you practice fasting? Yes No

11. How many meals do you usually eat per day? _____

12. How many snacks do you usually eat per day? _____

13. If you snack on a regular basis, what time(s) of day do you usually snack? _____

14. How many fruits did you eat yesterday? _____

15. How many vegetables did you eat yesterday? _____

16. Have you been testing your blood sugar? Yes No

If "yes"... continue. If "no" skip to question 17.

How many times a day are you checking your blood sugar? _____

How many days of the week do you usually check your blood sugar? _____

What is your usual blood sugar BEFORE meals? _____

Do you check your sugar 2 hours AFTER meals? Yes No

If yes, what is your usual blood sugar AFTER meals? _____

17. In the last 2 weeks, have had any low blood sugars (under 70)? Yes No

If yes, how many times have your had low blood sugars in the last 2 weeks? _____

18. Do you carry sugar or carb in case of a low blood sugar? Yes No

19. Please list all medicines you are taking for DIABETES (include dose and how often taken):

20. Do you exercise regularly outside of your job or normal daily routine? Yes No

If yes, what type of exercise do you do? _____

How many days a week do you usually exercise? _____

How many minutes do you usually exercise? _____

21. Have you had a dilated eye exam in the past 12 months? Yes No

22. Do you have an eye exam scheduled in the next month? Yes No

23. What do you hope to gain from our classes?

24. Has diabetes changed your life in any way? If so, please explain. Use back if needed.