Long Island
Community Hospital
109 West Main Street Patchogue, New York 11772
Phone: (631) 687-4188 Fax: (631) 687- 2879

PARTICIPANT SELF-ASSESSMENT OF DIABETES MANAGEMENT

NAME:	**DATE:**
ADDRESS:	**CITY:** **STATE:** **ZIP:**
PHONE: (Home) (Cell)	
Date of Birth: ____/____/____ **AGE:** _____	**Ethnic Background:** Caucasian / African American / Asian Hispanic / Native American **Primary Language:** **Gender:** Male Female

Type of diabetes: □ Type 1 □ Type 2 □ Prediabetes □ Gestational □ LADA (late onset diabetes adulthood) □ Not sure

Year / Age Diabetes Diagnosis: _____ / _____

HEIGHT _____ **WEIGHT** _____

Diabetes Medications: (check all that apply) **List other medications**

□ Metformin
□ Diabeta/Micronase (glyburide), Amaryl (glimepiride)/Glucotrol(glipizide) _____
□ Byetta/Victoza/Tanzeum/Adlyxin/Truclicity
□ Canagliflozin, Dapagliflozin, Empagliflozin _____
□ Januvia/Onglyza/Tradjenta/Nesina/Alogliptin
□ Lantus/Levemir/Trujeo/Basaglar/Tresiba _____
□ Insulin: Humalog/Novolog/Apidra/HumulinR/NovolinR
□ Insulin: HumulinN/NovolinN _____
□ Symlin injections
□ Other _____ _____

Current Medical History : (check all that apply)

□ High cholesterol
□ High blood pressure
□ Eye problems (glaucoma, retinopathy, cataracts)
□ Dental problems (gum disease/gingivitis)
□ Frequent urinary tract infection
□ Kidney problems
□ Sexual problems
□ Tingling/numbness in hands, feet and/or loss of feeling in feet
□ Depression

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How often do you miss taking your medications as prescribed?

□ Never □ Less than once every 6 months □ Less than once a month □ at least once a week

Have you had an emergency department visit/hospital admission in the last 12 MONTHS? □ YES □ NO

Was the visit or hospital admission diabetes-related? □ YES □ NO

I have had the following in the last 12 months (check all that apply):	**I have had the following in the last 6 months (check all that apply):**
□ Dilated Eye exam	□ A1C level (3-month blood sugar average)
□ Foot Exam	Recent result _____ month/year_____
□ Dental exam	□ Blood pressure
□ Flu vaccine	□ Cholesterol
□ Pneumonia vaccine	□ Weight
	□ Urine checked for protein

Do you drink alcohol? □ Never □ Occasionally □ YES ____ drinks per □ day □week

Do you smoke? □ Never □ Quit How long ago? _____

□ Yes Check all that apply □ cigar □ cigarettes □ chewing □ pipe

[redacted]

Currently employed?: □ YES □ NO **Occupation:** _____	**Marital status:** □Single □ Married □Divorced □ Widowed

I learn best by (Check all that apply):

□ Reading □ Audio visual □ Interactive discussion □ Observing □ Listening □ Application

Any cultural or religious practices that may influence how you care for your diabetes?

□ YES □ NO

Please describe:_____

Check any of the following that affect your ability to take care of your diabetes:

□ Transportation □ Financial □ Housing □ Social support □ Other

Please describe: _____

Do you have any difficulty (Check all that apply and explain)

□ Seeing □ Reading □ Hearing □ Speaking □ No difficulties

EXPLAIN: _____

Who do you live with? _____

Who do you look towards for support? _____

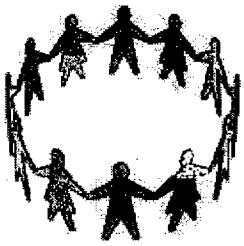
Any family with diabetes?_____

[redacted]

Are you: □ Pre– menopausal □ Menopausal □ Post Menopausal

Are you Pregnant? □ YES □ NO **If yes, expected delivery date?** _____	**Are you planning to become pregnant?** □ YES □ NO
Are you using birth control? □ YES □ NO	**Are you aware of the impact of diabetes on pregnancy?** □ YES □ NO

Revised 201811



STANFORD
PATIENT EDUCATION
RESEARCH CENTER

Self-Efficacy for Diabetes

We would like to know how confident you are in doing certain activities. For each of the following questions, please choose the number that corresponds to your confidence that you can do the tasks regularly at the present time.

1. How confident do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

2. How confident do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

3. How confident do you feel that you can choose the appropriate foods to eat when you are hungry (for example, snacks)?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

4. How confident do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

5. How confident do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

6. How confident do you feel that you know what to do when your blood sugar level goes higher or lower than it should be?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

7. How confident do you feel that you can judge when the changes in your illness mean you should visit the doctor?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

8. How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do?

not at all confident 1 2 3 4 5 6 7 8 9 10 totally confident

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*** PLEASE DO NOT WRITE BELOW THIS LINE ***		
CLINICAL ASSESSMENT SUMMARY		
Office use only **EDUCATION NEEDS / EDUCATION PLAN**		
☐ Diabetes Disease Process	☐ Using medication	☐ Risk Reduction Strategies
☐ Nutrition Management	☐ Monitoring Prevention	☐ Behavior Changes Strategies
☐ Physical Activity	☐ Acute Complications	☐ Psychosocial Adjustment
☐ Preventing Chronic Complications		
DATE:	**Clinical Signature:**	
DATE:	**Clinical Signature:**	