

**Diabetes Self-Management Program  
E.C.H.N.**

**LIFESTYLE QUESTIONNAIRE  
(Type 1, Type 2, Pre-Conception Care)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**GENERAL INFORMATION**

1. How long have you known that you have diabetes? \_\_\_\_\_

2. What were your thoughts when you were first told that you had diabetes? \_\_\_\_\_  
\_\_\_\_\_

3. Marital Status (please circle): Single Married Separated Divorced Widowed

4. Number of people living in household (excluding patient):

\_\_\_\_\_ Adults (18 years & over) \_\_\_\_\_ Children

5. Which family members, friends, or co-workers help you manage your diabetes?  
\_\_\_\_\_

6. Circle the highest level of school completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

7. What is your occupation? \_\_\_\_\_ Retired? Yes \_\_\_ No \_\_\_

8. Do you have any problems with: Seeing Yes \_\_\_ No \_\_\_

Hearing Yes \_\_\_ No \_\_\_

Reading Yes \_\_\_ No \_\_\_

9. Have you fallen within the last 30 days? Yes \_\_\_ No \_\_\_

If yes, what was the cause? \_\_\_\_\_

Do you need an assistive device (cane, wheelchair, walker)? Yes \_\_\_ No \_\_\_

**DIABETES RISK FACTORS (check all that apply)**

\_\_\_ Family history of diabetes (parent, brother or sister, child, other) Who? \_\_\_\_\_

\_\_\_ Age over 45 at diabetes diagnosis

\_\_\_ Overweight

\_\_\_ Physically inactive

\_\_\_ History of gestational diabetes (diabetes during pregnancy)

\_\_\_ Member of high-risk ethnic group: \_\_\_ African-American, \_\_\_ Hispanic American,

\_\_\_ Native American, \_\_\_ Asian American, \_\_\_ Pacific Islander

\_\_\_ Delivery of baby weighing more than 9 pounds

LIFESTYLE QUESTIONNAIRE (continued)

**MEDICAL HISTORY**

1. Do you have a primary care physician? Yes\_\_\_\_ No\_\_\_\_
2. How frequently do you see a physician regarding your diabetes care? \_\_\_\_\_  
\_\_\_\_\_
3. Have you been seen in the emergency room for your diabetes in the past 12 months?  
Yes\_\_\_ No \_\_\_
4. Do you smoke cigarettes? Yes\_\_\_ No \_\_\_ If yes, how many packs a day? \_\_\_\_\_
5. Do you drink alcohol? Yes\_\_\_ No \_\_\_ If yes, what do you drink? \_\_\_\_\_  
How often? \_\_\_\_\_
6. Do you have any of the following conditions along with your diabetes?  
\_\_\_\_ Cataracts / Glaucoma                      \_\_\_\_ Other Vision Problems  
\_\_\_\_ Stomach / Gastrointestinal Problems      \_\_\_\_ Skin Problems  
\_\_\_\_ Heart Problems                              \_\_\_\_ Foot Problems  
\_\_\_\_ High Blood Pressure                        \_\_\_\_ Kidney Problems  
\_\_\_\_ Sexual Problems                              \_\_\_\_ Pain or numbness in feet / legs

Please list any other medical problems and non-diabetes medications you are taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Do you have any allergies? \_\_\_\_\_
8. How often do you have your eyes examined? \_\_\_\_\_
9. When did you last see a dentist? \_\_\_\_\_
10. Do you see a foot care specialist? Yes \_\_\_ No \_\_\_

**DIET**

1. Do you eat 3 meals a day? Yes\_\_\_ No \_\_\_
2. At what times are you presently eating your meals?  
Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Supper \_\_\_\_\_
3. Do you have in-between meal snacks? Yes\_\_\_ No \_\_\_

LIFESTYLE QUESTIONNAIRE (continued)

DIABETES MEDICATION

If on Insulin:

1. What type of insulin do you take? How much? When?

AM Dose: \_\_\_\_\_ Type: \_\_\_\_\_ Units: \_\_\_\_\_ Time Taken: \_\_\_\_\_  
PM Dose: \_\_\_\_\_ Type: \_\_\_\_\_ Units: \_\_\_\_\_ Time Taken: \_\_\_\_\_

2. Where are injections given? (check all that apply)

Arm \_\_\_\_\_ Abdomen \_\_\_\_\_ Leg: \_\_\_\_\_ Buttocks \_\_\_\_\_ Other \_\_\_\_\_

3. Do you inject yourself? Yes \_\_\_ No \_\_\_ If no, who does? \_\_\_\_\_

4. Do you rotate injection sites? Yes \_\_\_ No \_\_\_

5. How many injections have you missed in the past 2 weeks? \_\_\_\_\_

6. Do you have any trouble drawing up the correct amount of your insulin? Yes \_\_\_ No \_\_\_  
If yes, describe: \_\_\_\_\_

7. Do you have any trouble injecting your insulin? Yes \_\_\_ No \_\_\_  
If yes, describe: \_\_\_\_\_

If on Oral Medications:

1. How many pills have you been told to take each day? \_\_\_\_\_

2. How many pills do you take each day? \_\_\_\_\_

3. How many times in the past 2 weeks have you missed taking your diabetes pills? \_\_\_\_\_

4. What are the names / dosages of your diabetes pills?

Name of pill	Strength	Time(s) of the day taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIFESTYLE QUESTIONNAIRE (continued)

**EXERCISE**

1. Is exercise a part of your diabetes regimen? Yes \_\_\_ No \_\_\_

If yes, describe type, frequency, and duration of exercises:

	Type	Number of Times / Week	Duration
(Example:	Brisk Walking	3	40 minutes each time)

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**MONITORING**

1. Do you test your blood sugar? Yes \_\_\_ No \_\_\_

If yes, what meter do you use? \_\_\_\_\_

2. How often have you checked your blood sugar in the last month?

\_\_\_\_\_ times / day, week, month

\_\_\_\_\_ no blood sugar checks

3. Have you had any of the following in the past 2 weeks?

\_\_\_\_\_ Tired, very thirsty          \_\_\_\_\_ Confusion

\_\_\_\_\_ Feelings of being shaky          \_\_\_\_\_ Up to the bathroom 2-3 times during night

4. How do you feel when you have a low blood sugar reaction?

\_\_\_\_\_

How often have you felt this way in the past 2 weeks? \_\_\_\_\_

5. How do you treat a low blood sugar reaction? \_\_\_\_\_

6. Is paying for diabetes supplies a problem? Yes \_\_\_ No \_\_\_

7. Last A1c (3 month average) blood test result \_\_\_\_\_

LIFESTYLE QUESTIONNAIRE (continued)

SUMMARY

1. What is causing you the most distress at this time? \_\_\_\_\_

\_\_\_\_\_

2. How do you manage stress? \_\_\_\_\_

\_\_\_\_\_

3. Are you currently receiving treatment for depression? Yes \_\_\_\_ No \_\_\_\_

If No, please answer the following. During the past month, have you often been bothered by:

a) feeling down, depressed or hopeless? Yes \_\_\_\_ No \_\_\_\_

b) having little interest or pleasure in doing things? Yes \_\_\_\_ No \_\_\_\_

4. Why are you coming to the Diabetes Self-Management Program? \_\_\_\_\_

\_\_\_\_\_

All information contained in this questionnaire will be kept confidential and used for Diabetes Instruction only.

Form completed by \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_