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
   _____Stomach / Gastrointestinal Problems
   _____Heart Problems
   _____High Blood Pressure
   _____Sexual Problems
   _____Other Vision Problems
   _____Skin Problems
   _____Foot Problems
   _____Kidney 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)

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 _____