AM Diabetes & Endocrinology Clinic

Chronicle Diabetes Assessment Form

Your diabetes educator has requested that you answer some questions about your diabetes in preparation for your education session. By answering these questions, you'll be providing valuable information to your diabetes care team. It is important that you answer as many questions as you can so your educator has a complete picture of your diabetes. It should only take you about 15 minutes to complete the questions.

If you have access to a computer you may log in to ADA Chronicle at _____ by using the email account/password given to you that was automatically generated through ADA Chronicle.

Username: _____ **Password:**_____

General Information:

Patient Name/ID

Full Name *Patient ID * Medicaid ID *Status * Chronicles ID

First:_____ MI: _____ Last:_____

Address 1:_____ Address 2: _____

City: _____ State: _____ Postal Code: _____

Email:_____ Work Phone: _____

Home phone: _____ Cell Phone: _____

Provider/Physician

Primary Physician _____

Physician Responsible for Diabetes Management_____

Demographics

Date of Birth
____/_____/_____

Gender
- ☐ Male
- ☐ Female

Race
- ☐ American Indian or Alaskan Native
- ☐ Black/African American
- ☐ White/Caucasian
- ☐ Middle Eastern
- ☐ Do not know
- ☐ Asian/Chinese/Japanese/Korean
- ☐ Hispanic/Chicano/Latino/Mexican
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other

Occupation
- ☐ Clerical
- ☐ Skilled Labor
- ☐ Retired
- ☐ Homemaker
- ☐ Other labor
- ☐ Disabled
- ☐ Sales
- ☐ Student
- ☐ Other
- ☐ Professional/Managerial
- ☐ Unemployed
- ☐ Do Not Know

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other
- ☐ Do Not Know

Education
- ☐ 8th Grade or Less
- ☐ Some High School
- ☐ High School Graduate/GED
- ☐ Some College
- ☐ College Degree (BA/BS)
- ☐ Graduate Degree

DSME Assessment

Diabetes History

Type of Diabetes

- ☐ Type 1
- ☐ Type 2
- ☐ Gestational
- ☐ Pre-diabetes
- ☐ Other
- ☐ Do Not Know

Year Diagnosed with Diabetes

_____/or (Approximate Year)_____

Blood Sugar Monitoring

Monitor your blood sugar: ☐ Yes ☐ No

Frequency of blood sugar checks: _____ x/day

Times of blood sugar checks: _____

Usual AM blood sugar (value): _____

Usual PM blood sugar (value): _____

Blood sugar value 1-2 hours after meals: _____

Brand of monitor used:_____

Model of monitor used: _____

Urine Ketone Testing

Performs Urine Ketone Test: ☐ Yes ☐ No

If yes, frequency of Urine Ketone Test: _____

Episodes of High Blood Sugar

Had recent episodes of high blood sugar?: ☐ Yes ☐ No ☐ Do Not Know

Frequency of episodes of high blood sugar?: _____

Blood sugar value?: _____

Symptoms and actions taken: _____

_____

Episodes of Low Blood Sugar

Had recent episode of low blood sugar?: ☐ Yes ☐ No ☐ Do Not Know

Frequency of episodes of low blood sugar?: _____

Blood sugar value?: _____

Symptoms and actions taken: _____

_____

Medical / Health History

Barriers to Care

Do any of the following things prevent you from taking care of yourself?

- ☐ Housing
- ☐ Utilities
- ☐ Food
- ☐ Transportation
- ☐ Caregiver
- ☐ Activities of daily living
- ☐ Support Network
- ☐ None of the above
- ☐ Other

Do you have difficulty with any of the following?

- ☐ Physical difficulty
- ☐ Seeing
- ☐ Hearing
- ☐ Reading
- ☐ Writing
- ☐ English as a second language
- ☐ None of the above

General Health Feelings

State your general feelings about your overall health: _____

_____

Pain

Do you have chronic pain?: ☐ Yes ☐ No

Where do you have chronic pain?: _____

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

Have you had treatment for your chronic pain?: ☐ Yes ☐ No

Have you had any treatment for your chronic pain?: ☐ Yes ☐ No

If yes, describe your treatment: _____

Rate your pain: (1 being slight and 10 being severe)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Allergies

List any allergies that you have: _____

Depression

Have you ever been diagnosed with depression?: ☐ Yes ☐ No

Over the past two weeks, how often have you been bothered by any of the following problems? Please choose an appropriate response for each item:

Little interest or please in doing things:

☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

Feeling down, depressed or hopeless:

☐ Not at all ☐ Several days ☐ More than ½ the days ☐ Nearly every day

Medical Problems

Have you been diagnosed with Coronary Artery Disease?	☐ Yes	☐ No
Have you ever suffered a Heart Attack?	☐ Yes	☐ No
Have you been diagnosed with High Cholesterol?	☐ Yes	☐ No
Have you been diagnosed with High Blood Pressure?	☐ Yes	☐ No
Have you ever suffered a Stroke/Transient Ischemic Attack?	☐ Yes	☐ No
Have you been diagnosed with Peripheral Vascular Disease (poor leg circulation)?	☐ Yes	☐ No
If yes, have you had an amputation? _____		
Have you been diagnosed with neuropathy (diabetes affecting the nerves)?	☐ Yes	☐ No
Is protein or albumin present in your urine? ☐ I don't know	☐ Yes	☐ No
Have you been diagnosed with Nephropathy (kidney disease)?	☐ Yes	☐ No
Have you had a kidney transplant?	☐ Yes	☐ No
Are you currently on dialysis?	☐ Yes	☐ No
Have you been diagnosed with Retinopathy (diabetes changed in retina)?	☐ Yes	☐ No
If yes, answer the following.		
Have you received laser treatments for diabetic problems?	☐ Yes	☐ No
Do you have cataracts?	☐ Yes	☐ No
Do you have Blindness (in *One* or *Both* eyes)?	☐ Yes	☐ No

Other _____

Have you fallen in the past month? Yes ☐ No ☐

If yes, How many times have you fallen? _____

Describe how you fell and if you were hurt? _____

Do you have any other medical conditions? (Please be specific): _____

_____

_____

Tobacco Use

Do you use tobacco? ☐ Yes ☐ No ☐ Quit

What type of tobacco do you use? ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chew ☐ Snuff

How much tobacco do you use per day? (packs, cans, cigars, etc.) _____

Have you ever been referred to counseling? Yes Referred Refused No

If you quit using tobacco, how long ago was it that you quit? _____ Year(s)

Alcohol User

Do you use alcohol? ☐ Yes ☐ No ☐ Quit

How often do you drink alcohol? Regularly (few times per week) Socially (few times per month)

Quantity (How many drinks?) _____per week _____per month

If you have quit, how long ago was it? _____Years

Health Status

Support Systems

Diabetes Support

Who do you live with?

☐ Live alone
☐ With spouse or partner
☐ With spouse/partner and children
☐ Other_____
☐ With children only
☐ With parents only
☐ With other family member or friends

Who helps you with your diabetes?

☐ Self ☐ Spouse ☐ Child ☐ Non Relative ☐ Other _____
☐ None of the above

Resource for Care

Do you have financial resource to care for your diabetes? ☐ Yes ☐ No ☐ Do Not Know

Do you have emotional resources to care for your diabetes? ☐ Yes ☐ No ☐ Do Not Know

Stress Management

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

_____

How do you manage your stress? _____

_____

Safety

Do you feel unsafe or threatened at: ☐ Home ☐ Work ☐ School? (*Please choose all that apply*)

Rate how safe you feel. Please choose the appropriate response for each item:
(1 being not safe and 10 being very safe)

1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Health Care Utilization

Past Diabetes Education

Have you had previous diabetes education? ☐ Yes ☐ No ☐ Do Not Know

If yes, what date did you receive diabetes education? Month _____ Day _____ Year _____

Where did you receive your diabetes education? _____

Hospital Admissions (pre education, not due to diabetes)

Have you had a hospital admission not due to diabetes in the past 12 months? ☐ Yes ☐ No

Approximate number of hospital admissions not due to diabetes in the past 12 months: _____

Total number of days not due to diabetes in past 12 months: _____

Reason for hospital admission not due to diabetes: _____

_____

Hospital Admission (pre education due to diabetes)

Have you had a hospital admission due to diabetes in the past 12 months? ☐ Yes ☐ No

Approximate number of hospital admissions due to diabetes in the 12 months: _____

Total number of days due to diabetes in past 12 months: _____

Reason for hospital admission due to diabetes: _____

_____

Emergency Room Visits (pre education, not due to diabetes)

Have you had an Emergency Room visit in the past 12 months not due to diabetes? ☐ Yes ☐ No

Approximate number of Emergency Room visits in the past 12 months not due to diabetes: _____

Reason for Emergency Room Visits not due to diabetes: _____

_____

Emergency Room Visits (pre education, due to diabetes)

Have you had an Emergency Room visit in the past 12 months due to diabetes? ☐ Yes ☐ No

Approximate number of Emergency Room visits in the past 12 months due to diabetes: _____

Reason for Emergency Room Visits due to diabetes: _____

_____

PCP Visits

Have you had primary care physician visits in the past 12 months? ☐ Yes ☐ No

Approximate number of Primary Care Physician Visits in the past 12 months: _____

Reason for Primary Care Physician Visits: _____

_____

Other Health Care Utilization

Have you had other specialist visits in the past 12 months? ☐ Yes ☐ No

Approximate number of specialist Visits in the past 12 months: _____

Reason for Other Specialist Visits: _____

_____

Method of Treatment

Changes in Eating

Has your eating habits changed since you have been diagnosed with diabetes?

☐ Yes ☐ No ☐ Do Not Know

If yes, what type of eating habits have you made?

☐ Eat Less ☐ Eat More Vegetables ☐ Eat Less Sugar
☐ Eat Less Fat ☐ Drink Less Pop, Juice ☐ Other_____

Eating Habits

How many times per day do you eat?

☐ One ☐ Two ☐ Three ☐ Four or More

What meals do you tend to skip?

☐ Breakfast ☐ Lunch ☐ Dinner ☐ None

Who is the primary cook in your house?

☐ Self ☐ Spouse ☐ Other _____

How often do you eat out?_____ (If you eat out less than once per week, please enter 0)

Do you have any special dietary needs? ☐ Yes ☐ No

Do you have any cultural or religious fasting or dietary restrictions?

☐ Yes ☐ No

Exercise

Do you exercise? ☐ Yes ☐ No

What type of exercise do you do?

☐ Walking ☐ Bike Riding ☐ Sports (basketball, softball, etc.)
☐ Running ☐ Golfing ☐ Aerobics
☐ Swimming ☐ Tennis ☐ Weight Lifting/Strength Training
☐ Dancing ☐ None ☐ Other _____

During a typical week:

How many days do you exercise? _____

How many minutes do you exercise (duration)? _____

Foot Self-Exam

How often do you examine your feet? (Please choose only one of the following)

☐ Daily ☐ Few times a month ☐ Never
☐ Few times a week ☐ Once a month
☐ Once a week ☐ Less than once a month

**WOMEN ONLY

Number of pregnancies: _____

Number of live births: _____

Contraceptive Method: _____

Had a baby weighing 9lbs or more at birth:	☐	Yes	☐	No
History of gestational diabetes:	☐	Yes	☐	No
Currently pregnant:	☐	Yes	☐	No
Planning to get pregnant:	☐	Yes	☐	No
Reached Menopause:	☐	Yes	☐	No

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Sexual Problems

Are you experiencing sexual problems:	☐	Yes	☐	No
If so, have you sought treatment for your sexual problem?:	☐	Yes	☐	No
If yes, was the treatment successful?:	☐	Yes	☐	No

Behavior Change Objectives

Personal Goals

I hope to gain the following from this educational program: _____
_____

List two things you feel that you need the most to help with to improve your diabetes:

1. _____
2. _____

Clinical and Lab Data

(Only Answer The Questions that You Know the Answers To)

**Approximate Date if you are not sure*

Available Lab Test		Date of Test: MM/DD/Year
Blood Pressure	_____ Systolic Over _____Diastolic	
Last Dental Exam	_____ Yes _____ No	
Last Eye Exam	_____ Yes _____ No	
Fasting Blood Glucose	_____	
Last Flu Vaccine	_____ Yes _____ No	
Last Comprehensive Foot Exam	_____ Yes _____ No	
Height	_____ Ft _____ Inches	
A1c (level)	_____%	
Cholesterol Test (Lipid Profile)	Total Cholesterol _____ HDL Cholesterol _____ LDL Cholesterol _____ Triglycerides _____	
Last Pneumonia Vaccine	_____ Yes _____ No	
Waist Circumference	_____ Inches	
Weight	_____lbs	
EKG	_____ Yes _____ No	

Medications

Current Medications: (List ALL medications; prescription/OTC (Over the Counter)/& Herbal

NAME	DOSE (# MG)	FREQUENCY (How Often Is It Taken)

Thank you for completing your self-assessment. The information you supplied will provide your diabetes care team with a better picture of your diabetes.