DM ASSESSMENT FORM

Name: ________________________________  □ Male  □ Female  Date: ______________

When were you diagnosed with diabetes? ________________________________________

Do you have:  □ Type 1 diabetes  □ Type 2 diabetes  □ Unsure

Do you monitor your blood sugar?  □ Yes  □ No  If yes, how many times per day? _____

Have you had diabetes education in the past? If so, when and where? ______________________________

Choose one of the following to describe your diabetes knowledge:

□ None- this is a new diagnosis for me and I have no information regarding the disease.
□ Limited- I have done some reading or have family members informing me.
□ Somewhat confident in my knowledge- I have attended diabetes education in the past, but struggle recalling all the information or would like a refresher.
□ Very confident in my knowledge- I feel well informed, I have attended diabetes education in the past and practice much of what was presented.

My reaction to having diabetes is best described by: (choose all that apply)

□ I do not believe I have diabetes
□ I am confident I can manage my diabetes with some education
□ Angry  □ Sad and/or worried  □ Overwhelmed  □ Frustrated

Do you take diabetes medications for diabetes?  □ Yes (check all that apply below)  □ No

□ Diabetes pills  □ Insulin injections  □ Other injections
□ Combination of pills/injections

If yes: Name/Dose/When taken: __________________________________________________________

How often do you miss a medication dose?______________________________________________

What is your main concern about diabetes? ______________________________________________

Most recent A1c: Date ____________________  Result: ______ %

Do you have:

□ High blood pressure  □ High cholesterol  □ Heart disease
□ Problems with kidneys  □ Problems with feet  □ Problems with eyes
□ Low blood sugar (< 70 mg/dL

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Other pertinent medical history: __________________________________________________________
_____________________________________________________________________________________

Height: ___________  Weight: ___________  Comfortable weight: _____________________________

Any recent changes? __________________________________________________________________
_____________________________________________________________________________________

How many meals per day do you eat? _______  How many snacks per day do you eat? _______

Do you exercise?
If yes: What activity?  How often and for how long each time? ______________________________
_____________________________________________________________________________________

Who is a primary person who might be an emotional support for you in dealing with diabetes?
_____________________________________________________________________________________

Last grade completed in school: ______________

Any conditions limiting your ability to learn how to manage your diabetes (for example, vision, hearing, physical)?  □ Yes  □ No
If yes, please describe: ________________________________________________________________

Do you have any cultural or religious practices that may impact your diabetes management?
□ Yes  □ No
If yes, please describe: ________________________________________________________________

Do you have financial concerns related to your diabetes management, such as cost of medicines, monitoring supplies, or food?  □ Yes  □ No
If yes, please describe: ________________________________________________________________

What are some of the questions you have about diabetes that you would like to talk about today?
_____________________________________________________________________________________
_____________________________________________________________________________________

Staff Use Only

□ Patient appropriate for education  □ Patient best served with individual education
□ Other: ________________________________________________________________

Educator signature: _________________________________________________________________

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