Avera Medical Group Endocrinology & Diabetes Education Questionnaire

1. What type of diabetes do you have?  □ Type 1  □ Type 2  □ I don't know

2. How long have you had diabetes? ______________________________________________________________

3. Have you received diabetes education with a nurse and dietitian in the past?
   □ No  □ Yes
   If yes: Where: ______________________________________________________________
   When: ______________________________________________________________
   □ Diabetes Nurse only
   □ Dietitian only
   □ Both Diabetes Nurse and Dietitian

4. Do you have a blood glucose meter?  □ No  □ Yes
   If yes: Brand: _______________________________________________________________________________
   How old is your meter?___________________________________________________________________
   How often do you test? __________________________________________________________________
   What time(s) of day do you test? ___________________________________________________________
   Blood sugar range: _____________________________________________________________________
   Do you code your meter? ______________________________________________________________
   Do you use your meter's control solution? _________________________________________________
   Do you use alternate site testing? __________________________________________________________

5. Are you taking diabetes medication?  □ No  □ Yes
   Past diabetes medicines: ________________________________________________________________
   Present diabetes medicine (dose and frequency): ______________________________________________

6. Do you take insulin?  □ No  □ Yes
   If yes: Brand: _______________________________________________________________________________
   Amount: ______________________________________________________________________________
   Time of day: ___________________________________________________________________________
   Where do you give your shots? (Check all that apply)
   □ Abdomen  □ Arms  □ Legs  □ Buttocks
   Do you rotate your injection sites?  □ No  □ Yes
   Do you ever forget your doses?

7. What type of insulin delivery device do you use?
   Pen: _______________________________________________________________________________________
   Vial and syringe: ______________________________________________________________________________
   Pump: _______________________________________________________________________________________
   Brand: ______________________________________________________________
   Basal Rate: ______________________________________________________________
   Bolus Ratio: ______________________________________________________________
   Sensitivity Factor: ______________________________________________________________
   Do you use the Bolus Wizard?  □ No  □ Yes

8. What types of insulin or diabetes pills have you used in the past?

9. Have you had any side effects or adverse reactions to any of your diabetes medications in the past?
   □ No  □ Yes  If yes, please list all side effects: ___________________________________________________________
10. Do you ever have low blood sugar reactions?  ❑ No  ❑ Yes
   How often: ________________________________________________________________
   What time(s) of day do you get low: _________________________________________
   What does your blood sugar read when you feel low: ___________________________
   Low blood sugar warning signs: ____________________________________________
   Usual treatment: __________________________________________________________
   Do you carry quick acting sugar with you all the time?  ❑ No  ❑ Yes  ❑ Don't know what this is
   Do you have a Glucagon kit?  ❑ No  ❑ Yes

11. Have you ever been admitted to the hospital because of your diabetes?  ❑ No  ❑ Yes

12. Do you have any complications from your diabetes?  ❑ No  ❑ Yes  (eyes, kidneys, neuropathy, etc.)
   Please list all complications: ________________________________________________

13. Do you wear / carry a medical alert identification for diabetes?  ❑ No  ❑ Yes
   Check all that apply:  ❑ Bracelet  ❑ Necklace  ❑ Wallet Card

14. Do you check your feet?  ❑ No  ❑ Yes  ❑ If yes, how often? __________________
   Please list any foot problems: ______________________________________________
   Any history of foot ulcers:  ❑ No  ❑ Yes

15. Daily schedule: Please write in the times for each item. If you don't have a set time, indicate a range.
   Get up: ______________________________________
   Breakfast: ____________________________________
   Morning snack: ________________________________
   Noon meal: __________________________________
   Afternoon snack: ______________________________
   Evening meal: ________________________________
   Bedtime snack: ________________________________
   Go to bed: ____________________________________
   Work hours (if you work outside the home): ________________________________

16. Do you get any regular scheduled exercise in addition to your job, housework, yardwork, etc.?  ❑ No  ❑ Yes
   If yes, what type of exercise: _____________________________________________
   How often: ____________________________ How long: __________________________

17. Have you had symptoms of elevated blood sugars recently? (Check all the apply):
   ❑ Hunger  ❑ Thirst  ❑ Dry Mouth  ❑ Frequent urination  ❑ Weight loss  ❑ Blurred vision

18. Do you check your urine for ketones?  ❑ No  ❑ Yes  ❑ Don't know what this is

19. Do you follow a diabetes meal plan?  ❑ No  ❑ Yes  ❑ If yes, please indicate type:
   ❑ Carbohydrate counting  ❑ Exchanges  ❑ Constant carbohydrate  ❑ No added sugar  ❑ Other: __________________

20. Do you have dental disease?  ❑ No  ❑ Yes  ❑ Date of last dental exam: ___________

21. Do you have eye disease?  ❑ No  ❑ Yes  ❑ Date of last eye exam: _______________

22. What information do you need to help take better care of your diabetes? _________________

23. How well do you follow your diabetes treatment plan?  Please circle:  Not at all  Very well
   1  2  3  4  5

Time: __________________ Date: __________________ Signature: ________________________