UW Medicine
VALLEY
MEDICAL CENTER

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

Patient Label

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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: _____

Patient Label