KING'S DAUGHTERS

Important Information About Your Appointment

The goal of your appointment with the King's Daughters Diabetes Education Team is to provide you with valuable information to assist in managing your diabetes.

What to Bring to Your Appointment

- If you are monitoring your blood sugars please bring your meter or continuous glucose monitoring (CGM) system and blood glucose log/diary.
- Please bring your completed Diabetes History Form (enclosed).

Diabetes History Form

KING'S DAUGHTERS

DATE: ____________________________

Legal Name: ____ Date of Birth: ______________________

Nickname: ____ Gender: ☐ Male ☐ Female ☐ Other

Street Address: ____

City: ____ State: ____________ ZIP: ______________

Email: ____ Phone: _____________________________

ABOUT YOU & YOUR FAMILY

Marital Status: ☐ Single ☐ Married ☐ Divorced/Widowed ☐ Other: ____________________________

How many people live in your household? ____

What is your native language? ☐ English ☐ Spanish ☐ Other: _______________

What is your race/ethnicity? ☐ Am. Indian/Alaskan Native ☐ Asian
☐ Black ☐ Hispanic ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other: ____

Your highest level of education: ☐ Elementary ☐ Middle/Jr. High ☐ High School/GED
☐ Tech/Certificate ☐ Associate's ☐ Bachelor's ☐ Graduate School

Do you have difficulty with any of the following:
☐ Reading ☐ Seeing ☐ Hearing ☐ Writing ☐ Mobility

How do you learn best? ☐ Reading ☐ Listening ☐ Watching ☐ Doing

Who helps you stay on track in managing your diabetes? ☐ Family ☐ Friends
☐ Co-Workers ☐ Online ☐ Publications ☐ Doctor/nurse ☐ None/no one

Do you use a computer to: ☐ Email ☐ Find health info
☐ Get support from people with similar health issues

Do you have any religious/cultural practices or beliefs that influence how you manage your diabetes?
☐ No ☐ Yes (please describe): ____

ABOUT YOUR OVERALL HEALTH

Do you have any of the following? ☐ Eye problems ☐ Kidney problems ☐ Dental problems
☐ High blood pressure ☐ Heart problems ☐ High cholesterol ☐ Sexual problems
☐ Depression ☐ Numbness/tingling in hands or feet

Tobacco Use

Do you use tobacco? ☐ No ☐ Quit ☐ Yes. If yes, please indicate how long:
☐ Less than a year ☐ 1-5 years ☐ 6-10 years ☐ 11-20 years ☐ > 20 years
Type Used: ☐ Cigars ☐ Pipe ☐ Vape ☐ Smokeless ☐ Other
☐ Cigarettes. Indicate packs per day smoked: ____________

Alcohol/Drug Use

Do you consume alcohol? ☐ No ☐ Yes. If yes, please indicate how often:
☐ Every day ☐ 1-2 times per week ☐ 3-4 times per week

☐ 3-4 times/month ☐ 1-2 times per month
Do you use drugs/substances not prescribed for you by a health professional? ☐ No ☐ Yes

Have you had any of the following in the past 12 months?
☐ Dilated eye exam ☐ Urine test for protein ☐ Foot self-exam
☐ Provider visit ☐ Dental exam ☐ Blood pressure check
☐ Weight ☐ Flu vaccine ☐ Pneumonia vaccine
☐ HgA1c ☐ Cholesterol/triglycerides check

ABOUT YOUR DIABETES

What type of diabetes do you have?
☐ Type 1 ☐ Type 2 ☐ Pre-Diabetes ☐ Gestational ☐ Unsure

How long have you had diabetes? ☐ Recently diagnosed ☐ < 1 year
☐ 1 - 4 years ☐ 5 - 6 years ☐ 7 - 10 years ☐ > 10 years ☐ > 20 years

Have you ever received education on caring for your diabetes? ☐ No ☐ Yes. When? ______________

In your own words, what is diabetes? ____

____

Do any of your immediate family members (spouse, children, parents, siblings) have diabetes?
☐ No ☐ Yes

Do you check your blood sugar levels? ☐ No ☐ Yes. If yes, how often?
☐ Occasionally ☐ Daily ☐ 2x per day ☐ 3-4x per day ☐ > 4 times per day

When do you check your levels (choose all that apply): ☐ Before breakfast ☐ After meals
☐ Before bed ☐ Other: ____

What is your blood sugar goal? ____

Do you check ketones in your urine? ☐ No ☐ Yes

In the last month, how often have you had a low blood sugar reaction?
☐ Never ☐ 1-2 times ☐ 3-4 times ☐More than 5 times

What time of day do you experience low blood sugar? ______________________________

What symptoms do you have with low blood sugar? ______________________________

What do you do to treat low blood sugar when you have it? ______________________________

Can you tell when your blood sugar is too high? ☐ Yes ☐ No

What do you do if your sugar is too high? ______________________________

____

Do you take any medications to manage your diabetes? ☐ No ☐ Yes. If yes, please indicate which medications you use: ☐ Pills/oral medication ☐ Insulin injection ☐ Other injectable medication

Do you ever have difficulty affording your medications? ☐ No ☐ Yes

Do you take your diabetes medications as prescribed? ☐ No ☐ Yes ☐ Sometimes

What concerns you the most about having diabetes: ______________________________

____

What is the hardest thing for you in caring for your diabetes: ______________________________

____

How do you feel about having diabetes: ______________________________

EXERCISE

On average, how many days per week do you engage in moderate to strenuous exercise – walking fast, running, jogging, dancing, swimming, biking or other activities that cause you to sweat?

☐ Never ☐ 1 day per week ☐ 2 days per week ☐ 3 days per week
☐ 4 days per week ☐ 5 days per week ☐ 6 days per week ☐ Every day

How many minutes per day do you engage in exercise at this level? ____________________

Are there any barriers that prevent you from exercising?

☐ Time ☐ Physical limitations ☐ Confidence ☐ Low energy
☐ Motivation ☐ Fear of low blood sugar ☐ No safe place to exercise
☐ Other: ______________________________

DIET & NUTRITION

Do you have a diabetes meal plan? ☐ No ☐ Yes. If yes, please describe: ____________________

____

Do you eat meals at the same time each day? ☐ Yes ☐ No

How many meals do you consume per day? ☐ One ☐ Two ☐ Three ☐ Four

How many times do you snack during the day? ☐ 1 to 2 ☐ 3 to 4 ☐ More than 4

Do you read the nutrition labels on foods to try to make healthier choices? ☐ Yes ☐ No

Do you shop for your food? ☐ Yes ☐ No. If no, who does the shopping?____________________

Do you cook your own meals food? ☐ Yes ☐ No. If no, who does the cooking?____________________

How often do you eat out each week (all meals):

☐ 0-1 times/week ☐ 2-3 times/week ☐ 4-6 times/week ☐ > 8 times/week

Other than your diabetes, do you have any special dietary needs? ☐ No ☐ Yes. If yes, please explain: ______________________________

Have your eating habits changed since your diagnosis? ☐ No ☐ Yes. If yes, how: ____________

____

PREGNANCY & CHILD BEARING

Do you currently use birth control? ☐ No ☐ Yes. If yes, type: ____________________

Are you: ☐ Pre-menopausal ☐ Menopausal ☐ Post-menopausal
☐ Planning to become pregnant ☐ Currently pregnant. Due Date: ____________________

Have you received education on diabetes and pregnancy? ☐ Yes ☐ No

Number of pregnancies: ____________ Number of live births: ____________

What was the birthweight of your child(ren)? ______________________________

How old are your living child(ren): ______________________________

Were you diagnosed with gestational diabetes during any pregnancy? ☐ No ☐ Yes

GENERAL WELL-BEING

Please indicate your level of agreement with the following statements:

I feel good about my general health.

☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

Diabetes interferes with other aspects of my life.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

I am under a lot of stress.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

I have some control over developing diabetes complications.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

I struggle with making lifestyle changes to care for my diabetes.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

I sometimes struggle to pay for my basic needs, such as housing, heat/electric, and food.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

In the past 12 months, I have worried that I would run out of food.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

In the past 12 months, transportation problems have kept me from attending medical appointments or getting prescription medications.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

In the past 12 months, transportation problems have kept me from getting to work and/or taking care of normal daily activities.
☐ Strongly Agree ☐ Agree ☐ Disagree ☐ Strongly Disagree ☐ Neutral

What are you most interested in learning during your Diabetes Education program?
☐ What is diabetes ☐ What I should eat/avoid ☐ Activity & exercise
☐ Medications ☐ Checking blood sugar ☐ High/low blood sugar
☐ Preventing complications ☐ Behavioral change ☐ Reducing risk
☐ Making lifestyle changes ☐ Emotional support
☐ Other: ____