Natividad
Inspiring healthy lives℠

Diabetes Education Center
1441 Constitution Boulevard, Salinas, CA 93906
(831) 755-6292 | www.natividad.com

Diabetes Self-Management Questionnaire for Prediabetes

General Information

1. Name:_____ Age:_____
2. Address:_____City:_____Zip Code:_____
3. Home phone:_____ Work phone:_____ Cell:_____
4. Your primary physician's name:_____
5. What is your race or ethnic background?
   - ❑ American Indian or Alaskan Native
   - ❑ Asian/Chinese/Japanese/Korean
   - ❑ Black/African American
   - ❑ Hispanic/Latino/Mexican
   - ❑ Native Hawaiian or other Pacific Islander
   - ❑ White/Caucasian
   - ❑ Other:_____

Socioeconomic / Support System

1. Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated
2. How many people live in your household?_____
3. Does anyone else who lives with you have prediabetes? ❑ No ❑ Yes: Who?_____
4. Is there anyone who will help you with your prediabetes care? ❑ No ❑ Yes

   If "yes," who?_____

   If different, who is your primary support person/caregiver? ❑ None ❑ Yes_____

   If "yes," who?_____
5. Occupation:_____ Work hours:_____
6. Last grade of school completed:_____
7. Any religion preference?_____

Cultural Influences

1. Do you have any special dietary needs, religious and/or cultural observances? ❑ Yes ❑ No

   If "yes," explain:_____
2. What is your language preference? Spoken:_____ Reading:_____

Diabetes History

1. How long have you had prediabetes or year diagnosed?_____
2. What type of diabetes do you have? ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Prediabetes ❑ Don't know

Chronic Complications - Are you aware of or have you ever been told by a doctor you have any of these problems? *Please rate as: L=Little M=Moderate S=Severe*

❑ Eye problems, explain:_____

❑ Heart/artery problems, explain:_____

❑ Nerve problems, explain:_____

❑ Teeth/gums problems, explain:_____

❑ Feet/leg problems, explain:_____

❑ Skin problems, explain:_____

❑ Gastrointestinal problems, explain:_____ Bowel Movements per day:___

❑ Sexual problems, explain:_____

❑ Kidney problems, explain:_____

❑ Frequent infections, explain:_____

❑ Other problems, explain:_____

Health Attitudes / Learning

1. How would you rate your understanding of prediabetes? ❑ Good ❑ Fair ❑ Poor
2. In your own words what is prediabetes?_____
3. Have you ever been instructed on diabetes care? ❑ No ❑ Yes: Where and by whom?

   _____
4. Do you have any physical limitations that may affect your ability to perform your self-care?
   ❑ Hearing problems ❑ Problems with the use of your hands
   ❑ Vision loss (not corrected by glasses or contacts) ❑ Problems with the use of your feet
5. How do you learn best?
   ❑ Written materials ❑ Verbal discussions ❑ Video ❑ Hands-on/Doing

   ❑ Other_____
6. Do you have any other barriers to learning (for example, problems with reading, writing, and/or understanding numbers)? ❑ No ❑ Yes: Describe barrier(s):_____

Medical History

1. Have you ever been diagnosed, ever been told, or have you had problems with the following?
   - ❑ High Blood pressure
   - ❑ High Cholesterol/Triglycerides
   - ❑ Kidney/Bladder problems
   - ❑ Eye or vision problems
   - ❑ Frequent nausea, vomiting, constipation, diarrhea
   - ❑ Surgery in the last 5 years
   - ❑ Heart disease/Chest pain
   - ❑ Thyroid disease
   - ❑ Asthma
   - ❑ Depression or anxiety
   - ❑ Circulation problems
   - ❑ Obesity
   - ❑ Shortness of Breath
   - ❑ Stroke
   - ❑ Numbness/pain/tingling of hands/feet
   - ❑ Other health problems:_____
2. Do you have any allergies? ❑ No ❑ Yes: Medication/foods:_____
3. Do you smoke? ❑ No ❑ Yes: How much? _____

   Have you ever smoked in the past? ❑ No

   ❑ Yes: How long did you smoke for?_____ How much?_____

   When did you quit?_____

   Have you ever tried to quit? ❑ No ❑ Yes: How long ago?_____

   Would you like information on how to quit? ❑ No ❑ Yes
4. Do you drink alcohol? ❑ No ❑ Yes If "yes," amount and type?_____

Family History

1. List any family members with diabetes:_____

   With high blood pressure:_____

   With heart attacks or other heart problems:_____

   With stroke:_____ With cancer:_____

Health Care Used in Past 12 months

1. When was your last physical examination?_____
2. How often do you see your regular doctor?_____
3. Have you been hospitalized within the last 12 months? ❑ No ❑ Yes

   If "yes," describe reason(s) and where:_____
4. Have you been to the emergency room within the last 12 months? ❑ No ❑ Yes

   If "yes," describe reason(s) and where:_____

Your Self Care Behaviors

Healthy Eating

1. Height:_____ Weight:_____ What weight are you comfortable at?_____
2. Has your weight changed in the past three months? ❑ No ❑ Yes If "yes," I've ❑ lost / ❑ gained_____ lbs.

   Was the weight change intentional? ❑ No ❑ Yes:_____

   Highest Weight/Age:_____ Lowest Weight/Age:_____ Provider/Physician Goal Weight:_____
3. Have you ever received diet counseling? ❑ No ❑ Yes If "yes," describe:_____
4. Do you have a current meal plan?_____ If so, what is it?_____
5. What is your biggest challenge to eating healthily?_____
6. How many times do you eat per day? ❑ Meals:_____ ❑ Snacks:_____
7. Times of meals: am:_____ noon:_____ pm:_____ snacks:_____
8. If you are a minor and/or a student, which meals do you eat at school? _____
9. How often do you eat/drink (answer **per day** or **per week**):

   ❑ Fruit:_____ ❑ Vegetables:_____ How much water per day?_____ ❑ Alcohol:_____

   ❑ Milk:_____ ❑ Fat-free ❑ 1 % ❑ 2 % ❑ Whole ❑ Soy ❑ Almond ❑ Other milks _____

   Beverages with sugar: Juice:_____ Soft drinks:_____ Others:_____

   Sweets/desserts:_____ Sugar-free desserts/drinks:_____

   Starches eaten: State number of servings eaten **meal or per day**

   ❑ Bread:_____ ❑ Cereal:_____ ❑ Beans:_____ ❑ Tortillas:_____ ❑ Rice:_____

   ❑ Pasta:_____ ❑ Corn/Peas:_____ ❑ Potatoes:_____ ❑ Oats:_____ ❑ Other:_____

   Meats/Proteins: State number of times eaten **per week**

   ❑ Chicken:_____ ❑ Red Meats:_____ ❑ Fish:_____ ❑ Turkey:_____

   ❑ Pork:_____ ❑ Eggs:_____ ❑ Cheese:_____ ❑ Nuts/Nut butters:_____

   ❑ Other:_____

   Cooking Oil/Fat used: ❑ Lard/Shortening:_____ ❑ Butter/Margarine:_____ ❑ Olive:_____

   ❑ Vegetable/Corn:_____ ❑ Canola:_____ ❑ Peanut:_____

   ❑ Other:_____
10. Who does the cooking?_____ Who usually does the grocery shopping?_____
11. How many times during the week do you eat away from home?_____
12. How often is your meal away from home: Cafeteria style:_____ Fast food:_____ Buffet:_____

    Sit-down restaurant:_____ Other:_____
13. How is your food usually prepared? ❑ Fried ❑ Baked ❑ Broiled ❑ Grilled ❑ Steamed ❑ Boiled

❑ Other forms(s)_____

14. How would you describe your portions? ❑ Small ❑ Average ❑ Large
15. How would you describe your appetite? ❑ Increased ❑ Normal ❑ Decreased
16. List any food allergies or intolerance:_____

_____

17. Any other special diet needs:_____

_____

18. How do mood/stress affect your eating?_____

_____

Food Insecurity

1. In the last 12 months, did you ever cut the size of your meals or skip meals because there wasn't enough money for food? ❑ No ❑ Yes

   If yes, how often did this happen? ❑ Almost every month ❑ Some months but not every month ❑ In 1-2 months
2. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food? ❑ No ❑ Yes
3. In the last 12 months, were you ever hungry but didn't eat because you couldn't afford enough food? ❑ No ❑ Yes
4. Answer the following statements regarding your food situation:

   1) "The food that I bought just didn't last, and I didn't have money to get more."

   ❑ Often true ❑ Sometimes true ❑ Never true

   2) "I couldn't afford to eat balanced meals."

   ❑ Often true ❑ Sometimes true ❑ Never true

Being Active

1. Do you exercise regularly? ❑ No ❑ Yes Types of exercise(s):_____

   How many days per week do you exercise:_____ How many minutes do you exercise per day?_____

   What time of day do you exercise?_____

   Note: If you are a minor/student, please include exercise during PE in school.
2. List any problems with exercise:_____
3. How important is it to you to be active, where **0** is not important at all and **10** is very important? *(Circle one):*

   0 1 2 3 4 5 6 7 8 9 10
4. How sure are you that you can be active, where **0** is not sure and **10** is very sure? *(Circle one):*

   0 1 2 3 4 5 6 7 8 9 10

Taking Medications

1. Do you take pills for your prediabetes? ❑ No ❑ Yes: What times?_____
2. Any side effects from the medications that you know of? ❑ No ❑ Yes:_____
3. Do you take any additional nutritional supplements? ❑ Vitamins ❑ Herbal supplements

   ❑ Other:_____

   Have you ever forgotten to take your prediabetes medication? ❑ No ❑ Yes: How often?_____
4. How important is it to you to take your medicines, where **0** is not important at all and **10** is very important? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10
5. How sure are you that you can take your medicines, where **0** is not sure at all and **10** is very sure? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

Problem Solving

1. 1.Have you ever had high blood sugar?
   ❑ Don't know ❑ No ❑ Yes

   If "yes," how did you feel?_____

   How did you treat it?_____

   Did you require assistance or hospitalization for it? ❑ No ❑ Yes: When/Where?_____

Stress

1. Is there much stress in your life? ❑ No ❑ If "yes," explain:_____
2. What do you do to handle stress in your life?_____
3. How important is being able to problem solve when being faced with everyday and/or challenging decisions, where **0** is not important at all and **10** is very important? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10
4. Do you feel you can problem solve when faced with everyday and/or challenging decisions, where **0** is not sure at all and **10** very sure? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10
5. Do you perceive problems with your diabetes management, where **0** is none perceived and **10** is perceive many? *(Circle one):*
   0 1 2 3 4 5 6 7 8 9 10

Healthy Coping

1. How would you describe your general health? ❑ Good ❑ Fair ❑ Poor
2. Is your health important to you? ❑ All the time ❑ Sometimes ❑ Only when ill ❑ Not at all
3. How do you feel about having prediabetes?_____

4. Are you currently experiencing any of the following?
   ❑ No problems ❑ Recent death
   ❑ Separation ❑ Divorce ❑ Illness ❑ Unemployment
   ❑ Financial difficulties ❑ Housing problems ❑ Loneliness ❑ Confusion
   ❑ Depression symptoms ❑ Thoughts of hurting yourself ❑ Other:_____

5. Do you have history of depression? ❑ No ❑ Yes: How often do you feel depressed?
   ❑ A lot ❑ Some ❑ A little ❑ Not at all

Goal Setting

1. What areas of prediabetes would you like to learn more about?
   ❑ What is prediabetes? ❑ High blood sugar ❑ Diet ❑ Exercise
   ❑ Stress ❑ Pregnancy

2. Having prediabetes means you may need to make changes; if any, what changes would you like to make now?
   ❑ Being active ❑ Eating healthily ❑ Problem solving for blood sugars ❑ Living with prediabetes
   ❑ Using healthy coping strategies ❑ Reducing risks of diabetes complications ❑ None of the above
   ❑ Other:_____

Women Only

1. Date of last Pap smear/pelvic exam:_____ Last mammogram:_____

2. How many pregnancies have you had?_____ Abortions/miscarriages:_____

3. How many living children do you have?_____ Complications of pregnancy?_____

4. Were you ever told you had diabetes in pregnancy? ❑ No ❑ Yes

5. Did you have any children that weighted over 9 pounds at birth? ❑ No ❑ Yes

What method of birth control do you use?
   ❑ No method is used ❑ Postmenopausal ❑ Birth control pills ❑ Condoms
   ❑ Norplant/Implanon/Nexplanon ❑ Tubal ligation ❑ Depo-Provera shots ❑ IUD
   ❑ Other:_____

Women Only: Pregnancy

1. Are you currently pregnant? ❑ No ❑ Yes If "yes," what is your due date?_____

2. When was your last menstrual period?_____

3. Are you planning to become pregnant? ❑ No ❑ Yes
   If "yes," are you aware of the effects of diabetes on pregnancy and of pregnancy on diabetes? ❑ Yes ❑ No