Diabetes Management Assessment Form

The following questions, which should be asked and answered during an interactive session with the patient, are designed to enable healthcare providers to identify patients with diabetes who, despite therapy, are not achieving their goals (A1C<7%). Review of the patient's responses should help clarify barriers to controlling glucose levels and optimal management of diabetes.

Patient's Name: _____ **Patient's DOB:** _____

Fasting Blood Glucose (date/result): _____ **Most Recent A1C, if available (date/result):** _____

1. Have you ever been told by a healthcare professional that you have diabetes? ❑ Yes *(If yes, skip to question 3)* ❑ No

2. Have you ever been told by a healthcare professional that your blood sugar is too high (fasting blood sugar 100-125 mg/dL) and you could get diabetes? ❑ Yes ❑ No

(If the patient has high blood sugar but not yet diabetes, do not proceed with the questionnaire and refer to ADA 2007 Clinical Practice Recommendations on the screening and criteria for diagnosis of diabetes.)

3. Are you taking oral medications to treat your diabetes?
❑ Yes ❑ No

a. How many oral medications are you taking to treat your diabetes? _____

b. Name(s) of medication(s) and dosage(s):

_____

_____

c. When and how often do you take your oral medications?

_____

_____

4. Are you currently taking insulin to control your diabetes?
❑ Yes ❑ No

a. Name(s) of medication(s) and dosage(s):

_____

_____

b. When and how often do you take your insulin medications?

_____

_____

5. Do you regularly measure your blood sugar level and record results? ❑ Yes ❑ No *(If no, skip to question 7)*

6. How many times a day do you measure your blood sugar level?
❑ 1–2 ❑ 3–4 ❑ 5+

7. Do you have your A1C tested at least twice a year?
❑ Yes ❑ No ❑ Don't know what A1C is

(Patients should have their A1C tested quarterly if they are not meeting their target glycemic goals or their therapy has changed.)

8. Are you following a meal plan? ❑ Yes ❑ No

a. Do you count carbohydrates? ❑ Yes ❑ No

9. Has your weight changed in the last 6-12 months? ❑ Yes ❑ No

a. If yes, did you gain or lose weight and how many pounds?

_____

10. Are you physically active at least 30 minutes most days of the week? ❑ Yes ❑ No

11. Have you been in the emergency room or hospitalized for a condition related to your diabetes in the last 12 months (date/results)? ❑ Yes ❑ No

_____

12. Have you had a thorough foot examination in the last 12 months (date/results)? ❑ Yes ❑ No

_____

13. Have you had your eyes checked by a specialist in the last 12 months (date/results)? ❑ Yes ❑ No

_____

14. Have you had your lipids/cholesterol checked in the last 12 months (date/results)? ❑ Yes ❑ No

_____

15. Have you had a microalbuminuria test/urine test for protein in the last 12 months (date/results)? ❑ Yes ❑ No

_____

16. Do you have high blood pressure? ❑ Yes ❑ No

a. If yes, do you take medication to control your blood pressure? ❑ Yes ❑ No

b. Name(s) of medication(s) and dosage(s)?

_____

_____

17. Do you take medication(s) for a condition/illness other than diabetes? ❑ Yes ❑ No

a. Name(s) of medication(s) and dosage(s):

_____

_____

_____

_____

Provider's Notes:

Patient's overall effectiveness at controlling his/her diabetes *(please circle one):* Excellent Good Fair Poor

If patient is not controlling his/her diabetes, list possible steps that can be taken to improve control: _____

_____

Patient's risk for complications/comorbidities *(please circle one):* High Medium Low

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