America's 1st Choice of South Carolina, Inc.
PO Box 15804, Tampa, FL 33684-9846
Health & Wellness Material

Diabetes Health Assessment Form

Date of Birth:
Phone#:

Date:
Member Name:
Member Address:
City State Zip:

ID#:

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your disease status and ensure you are properly managing your disease.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

If you received this form in error and don't have this disease, check the box and return the form to us in the supplied envelope without answering any of the questions below. ❑ No, I don't have Diabetes.

1. Which type of medication do you take for your Diabetes? (check one) ❑ Pills only ❑ Insulin only ❑ Both pills and insulin ❑ Other medicine by shot ❑ None
2. If you take insulin, how often do you take it: (check one) ❑1 time a day ❑ 2-3 times a day ❑ More than 3 times a day ❑ On an insulin pump
3. How many times in the past year have you had to go to the hospital due to your Diabetes? (check one) ❑ 0 ❑ 1 time ❑ 2-3 times ❑ More than 3 times
4. How often do you see your doctor about your Diabetes? (check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ 3 times a year or greater
5. How often do you have your blood A1C checked? (check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ Never ❑ Don't know what this is?
6. What was your last HgbA1C result? (check one) ❑ 6.5 or less ❑ Between 6.6 and 7.5 ❑ 7.6 to 9.0 ❑ More than 9.0 ❑ Don't know
7. Do you use a glucometer (blood sugar testing device)? ❑Yes ❑ No
8. On a daily basis, how often do you check your blood sugar? (check one) ❑ 1 time ❑ 2 times ❑ 3 times ❑ 4-5 times ❑ More than 5 times ❑ Never
9. What does your fasting (first one in the morning) blood sugar usually run? (check one) ❑ 110 or less ❑ 111-120 ❑ 121-140 ❑ More than 140 ❑ Don't know
10. What does your blood sugar usually run if taken 2 hours after eating? (check one) ❑ 110 -120 ❑ 121-140 ❑ 141-180 ❑ More than 180 ❑ Don't know

Diabetes Health Assessment Form *(continued)*

11. During a week, how often does your blood sugar drop below 70?
(check one) ❑ Never ❑ 1 time a week ❑ 2-3 times a week ❑ More than 3 times a week ❑ Don't know

12. How do you change your diet in order to control your blood sugar?
(check one) ❑ Control my carbohydrate intake ❑ Control only my sugar intake ❑ Don't follow a diet

13. When was the last time you attended Diabetes self management education classes?
(check one) ❑ Less than 1 year ago ❑ 1-2 years ago ❑ 3-5 years ago ❑ More than 5 years ❑ Never

14. Do you have any wounds that are not healing properly? ❑ Yes ❑ No

15. Do you have any of the following problems: (Check all that apply)
❑ Cramping/pain in legs or buttocks after walking ❑ Pins/needles/burning to legs and/or feet
❑ Redness/swelling in legs ❑ Lack of feeling in fingers or toes

16. How often do you have your feet checked? ❑ 1 time a year ❑ 2 times a year ❑ Never

17. How often do you have a dilated eye exam? ❑ 1 time a year ❑ Never

18. How often do you have your urine checked? ❑ 1 time a year ❑ 2 times a year ❑ Never

19. Does having Diabetes keep you from being active or socializing as much as you would like? ❑ Yes ❑ No

20. Does having Diabetes make you feel depressed? ❑ Yes ❑ No

21. How often do you exercise?
(check one) ❑ 1-2 days a week ❑ 3-4 days a week ❑ 5-7 days a week ❑ Not routinely

22. Do you take any medicine for high blood pressure? ❑ Yes ❑ No

23. Does your blood pressure usually run higher than 140/90? ❑ Yes ❑ No ❑ Don't know

24. Do you take any medicine for high cholesterol? ❑ Yes ❑ No

25. Do you take any medicine for chest pain? ❑ Yes ❑ No

26. If yes, has your chest pain been getting worse or more often? ❑ Yes ❑ No

27. Do you think your Diabetes has become better or worse over the past year?
(check one) ❑ Better ❑ Worse ❑ Stayed the same

28. How would you rate your ability to take care of yourself with the support you have in place?
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor