

## PREDIABETES SELF-ASSESSMENT

### DIABETES CENTRE (DC)

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
                            day                      month                      year

#### Instructions for Completing this Questionnaire

Thank you for completing this questionnaire at home. This information is important in helping us get to know you and will also allow more time for us to talk with you at your appointment. **An appointment has been arranged for you at the Diabetes Centre on \_\_\_\_\_.**

- Please print clearly.** If you have any problems, have someone help you complete the form.
- Please follow the instructions in the cover letter for returning this form to your Diabetes Centre.
- If you are unsure about any questions on this form, please call the Diabetes Centre at \_\_\_\_\_.
- Please bring the following with you to your **first appointment**:
  - Your completed **nutrition questionnaire/food record** (enclosed).
  - Your Nova Scotia Health Card.
  - The **completed Medication Sheet** (enclosed).
  - Your reading glasses (if worn).

#### DIABETES-RELATED INFORMATION (please print):

**When** did you find out that your blood sugar was above normal? \_\_\_\_\_ (month) \_\_\_\_\_ (year)

Do you have a family history (parents, sisters/brothers, or children) of the following:

Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Yes	If yes, who: _____
Heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Yes	If yes, who: _____
High blood pressure	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Yes	If yes, who: _____
Obesity	<input type="checkbox"/> No	<input type="checkbox"/> Don't know	<input type="checkbox"/> Yes	If yes, who: _____

#### HEALTH STATUS (please print):

Do you take any medications (including vitamins or supplements)?  No  Yes

**If yes, fill in the enclosed medication sheet.**

Are you **allergic** to anything?  No  Yes

Drug: \_\_\_\_\_ Food: \_\_\_\_\_

Other: \_\_\_\_\_

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**HEALTH STATUS (cont):**

Have you been seriously ill or **in the hospital in the last 12 months**?  No  Yes

If yes, what was this illness or the reason for your stay? \_\_\_\_\_

Do you have any of the following **health problems**? Please check (✓) the appropriate box(es).

**None**

Hearing problems

Eye or vision problems

High blood pressure

Heart problems

Stroke

Cholesterol problems

Breathing problems

Circulation problems

Arthritis

Cancer

Depression

Chronic pain

Kidney problems

Urinary infections

Bladder problems

Bowel problems

Thyroid problems

Other: \_\_\_\_\_

Have you ever been diagnosed with gestational diabetes?  No  Yes

Do you **smoke**?  No  Yes If yes, how much? \_\_\_\_\_

*Cigs or packages per day (Circle one)*

Did you ever smoke?  No  Yes When did you quit? \_\_\_\_\_

Do you drink **alcohol**?  No  Yes If yes, what do you drink? \_\_\_\_\_

How much and how often? \_\_\_\_\_

Do you use **social drugs** (For example, marijuana, hash)?  No  Yes

If yes, what do you use and how often? \_\_\_\_\_

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**SOCIAL ASSESSMENT (please print):**

Do you **live alone**?  No  Yes If no, whom do you live with? \_\_\_\_\_

Who do you rely on when you **need help/support**?

spouse/partner  mother or father  friend  other: \_\_\_\_\_

Do you **work outside the home**?  No  Yes  Retired

If yes, what do you do? \_\_\_\_\_  full-time  part-time  shift work

Do you have financial concerns?  **none**  food  other: \_\_\_\_\_

Do you have a **drug plan**?  No  Yes

Do you have any religious, family, or cultural practices that influence how you care for your health?  No  Yes \_\_\_\_\_

**PHYSICAL ACTIVITY (please print):**

Are you **physically active**?  No  Yes  Advised not to by Doctor

Type of activity/exercise? \_\_\_\_\_

How often do you do it? \_\_\_\_\_

Do you have any specific hobbies/recreational interests?  No  Yes

If yes, please describe: \_\_\_\_\_

How many hours a day do you spend in front of the TV and/or computer? \_\_\_\_\_

What stops you from being more active (what are the barriers)? \_\_\_\_\_

**NUTRITION—DIETARY HISTORY (please print):**

What is your **usual weight**? \_\_\_\_\_ What would you like to weigh? \_\_\_\_\_  
pounds/kgs (circle) pounds/kgs (circle)

Has your **weight changed** in the last 6 months?  No  Yes

If yes, how much have you  lost or  gained? \_\_\_\_\_ pounds/kgs (*circle*)

Have you ever **been on a diet** (meal plan) in the past?  No  Yes

If yes, when and what was it for? \_\_\_\_\_

Check (✓) any of the following **problems**:

Constipation and/or diarrhea Explain: \_\_\_\_\_

Chewing and/or swallowing Explain: \_\_\_\_\_

Appetite Explain: \_\_\_\_\_

Do you eat in **restaurants**?  No  Yes

If yes, how often and what foods do you usually choose? \_\_\_\_\_

Do you eat in response to  stress and/or  boredom?  No  Yes

If yes, how often and what do you choose? \_\_\_\_\_

Do you ever **skip meals**?  No  Yes

If yes, how often? \_\_\_\_\_ (times per week) What meal or meals? \_\_\_\_\_

Why do you skip meals? \_\_\_\_\_

**NUTRITION—DIETARY HISTORY (cont):**

Have you **changed your** eating habits in the **past 6 months**?  No  Yes  
 If yes, in what way?  how much you eat  types of food you eat  when you eat  
 Explain: \_\_\_\_\_  
 \_\_\_\_\_

**PERSONAL NEEDS (please print):**

Do you want to make changes to how you eat or your exercise (if necessary)?  No  Yes  
 If yes, what changes would you like to make? \_\_\_\_\_  
 \_\_\_\_\_

Please list any specific questions you may have. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What would you **most** like to discuss on your first visit? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What is the best way **for you** to learn new information?

Listening  Talking  Videos  Reading material  Internet

**Person filling out information on this form please sign here:**

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
 (If someone other than the client, state relationship) (day/month/year)

**Thank you for filling out this questionnaire.  
 We look forward to meeting with you. Thank you!**

**OFFICE USE ONLY**

**Name and signature required by those reviewing this form.**

Date	Name (Print)	Signature	Initials	Discipline