



P.O. Box 153178, Tampa, FL 33684  
Health and Wellness Material

# Diabetes Health Assessment Form

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

Phone#: \_\_\_\_\_

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 health status and ensure you are properly managing your health.

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 health, 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.**

<b>1. Which type of medication do you take for your Diabetes?</b> (check one) <input type="checkbox"/> Pills only <input type="checkbox"/> Insulin only <input type="checkbox"/> Both pills and insulin <input type="checkbox"/> Other medicine by shot <input type="checkbox"/> None
<b>2. If you take insulin, how often do you take it:</b> (check one) <input type="checkbox"/> 1 time a day <input type="checkbox"/> 2-3 times a day <input type="checkbox"/> More than 3 times a day <input type="checkbox"/> On an insulin pump
<b>3. How many times in the past year have you had to go to the hospital due to your Diabetes?</b> (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time <input type="checkbox"/> 2-3 times <input type="checkbox"/> More than 4 times
<b>4. How often do you see your doctor about your Diabetes?</b> (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time a year <input type="checkbox"/> 2 times a year <input type="checkbox"/> 3 times a year or greater
<b>5. How often do you have your blood HbA1c checked?</b> (check one) <input type="checkbox"/> 0 <input type="checkbox"/> 1 time a year <input type="checkbox"/> 2 times a year <input type="checkbox"/> Never <input type="checkbox"/> Don't know what this is?
<b>6. What was your last HbA1c result?</b> (check one) <input type="checkbox"/> 6.5 or less <input type="checkbox"/> Between 6.6 and 7.5 <input type="checkbox"/> 7.6 to 9.0 <input type="checkbox"/> More than 9.0 <input type="checkbox"/> Don't know
<b>7. Do you use a glucometer (blood sugar testing device)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>8. On a daily basis, how often do you check your blood sugar?</b> (check one) <input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 times <input type="checkbox"/> 5 times or more <input type="checkbox"/> Never
<b>9. What does your fasting (first one in the morning) blood sugar usually run?</b> (check one) <input type="checkbox"/> 110 or less <input type="checkbox"/> 111-120 <input type="checkbox"/> 121-140 <input type="checkbox"/> More than 140 <input type="checkbox"/> Don't know
<b>10. What does your blood sugar usually run if taken 2 hours after eating?</b> (check one) <input type="checkbox"/> 110 -120 <input type="checkbox"/> 121-140 <input type="checkbox"/> 141-180 <input type="checkbox"/> More than 180 <input type="checkbox"/> 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 times a week     3 times or more a week     Don't know**12. How do you change your diet in order to control your blood sugar?**(check one)     Limit carbohydrate intake     Limit 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 toe

**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