

JOHNS HOPKINS DIABETES EDUCATION PROGRAM

DIABETES SELF-MANAGEMENT ASSESSMENT

Date: _____

JHH # _____

I. General Information						
Name: _____						
Address: _____						
Phone: Home: _____		Work: _____		Email: _____		Fax: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: _____	Age: _____	Height: _____	Weight: _____	Goal Weight: _____	
Occupation: _____						
Food Allergies: _____						

II. Health Problems Other Than Diabetes:

- | | | |
|----------------------------------------------|-----------------------------------------------|---------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Eye disease | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerve disease | _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Foot problems | _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver disease | |
| <input type="checkbox"/> Thyroid | <input type="checkbox"/> Circulation problems | |
| <input type="checkbox"/> Stomach/Ulcers | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Kidney/Bladder | <input type="checkbox"/> Skin problems | |
| | <input type="checkbox"/> High Cholesterol | |

Do you inspect your feet? Y N How often? _____

Physician's Name: _____ Address _____

Date Diabetes Diagnosed: _____ Medications for Diabetes: _____

Medications for High Blood Pressure: _____ Cholesterol: _____

Other _____

Last Seen By Dietician: _____

VII. Exercise/Activity

Do you have a regular exercise routine? Y N

TYPE OF EXERCISE	NUMBER OF TIMES A WEEK	LENGTH OF TIME SPENT

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Describe your daily activity level:

Sedentary (sit most of day) Moderate (on feet most of day) Light (desk work) Heavy (manual labor).

VIII. Eating Habits

Do you follow a meal plan? Y N Calorie level? _____ Carbohydrate Grams? _____

Who shops for food? _____ Who cooks? _____

Do you/or the shopper read food labels? Y N What do you look for? _____

FLUIDS: Usual amounts taken daily or as specified – by ounces, cans, jiggers, etc.

Water: _____ Milk: _____ kind: _____ Fruit Juice: _____ Sodas: Reg. _____ Diet _____

Coffee: _____ with: _____ Tea: _____ with: _____ Beer: _____ daily: _____ weekend: _____

Wine: _____ daily: _____ weekend: _____ Whiskey: _____ daily: _____ per week _____ weekend _____

Please list the meals and snacks you usually eat below. Please note the time of day for meals and snacks and the food eaten, i.e., medium baked potato, fried chicken, broiled steak, broccoli, corn, banana, desserts, beverages, etc. If possible, note the approximate serving size of each food.

TYPICAL MEAL PATTERN	
TIME/PLACE	USUAL INTAKE
BREAKFAST:	
LUNCH:	
DINNER:	

SNACKS	
TIME/PLACE	USUAL INTAKE

Are you able to follow a meal plan no matter where you eat? Y N Sometimes

MEALS EATEN AWAY FROM HOME		
MEAL	TYPE OF PLACE	HOW MANY TIMES/WEEK
Breakfast		
Lunch		
Dinner		