Diabetes Self Care Assessment Form

Last Name, First Name _____ Birthdate _____ Age_____

Visit Date	Weight (up or down?)	BP	Glucose Range	Issues?

Phone _____ Who do you live with? _____ Feel safe? _____

How many years with diabetes? _____ Family history _____

How often do you check blood sugars _____ Highest? Lowest BG past few weeks? _____

Hypoglycemia? Yes ___ No____ What action? _____ Have Med ID? Yes ____ No _____

Diabetes Pills _____ How often take? _____

Diabetes Injections or insulin _____Site check _____

Other meds BP/ lipids/nerves _____

How many hours do you sit a day? _____ Daily activity _____

Drinks of alcohol a day? None 1 2 3 4 5+ Tobacco _____ Marijuana/Drug use _____

Do you have chronic pain or neuropathy Y N If yes what tx? _____

Depression or other Mental health issues? Yes No Sleep hrs. _____ Sex Life? _____

Breakfast Dinner

Lunch Snacks

What beverages? Referral to RD? Y N _____

Health Checks Last eye exam ____ Last foot exam _____ Last dental visit ____ Brush___ Floss ___

Hepatitis Vaccine _____ Last flu shot _____ Last pneumonia vaccine _____ COVID Vaccine? _____
Feet appearance:

Date	A1c	LDL	HDL	Trig	GFR	UACR	ALT/AST/PLT – FIB-4	TSH