AAHP Diabetes Class Registration **Date__________** **Group # ________** **Reg. #_______**

Name ____

Address ____

City________________________ State ________________ Zip Code __________

Phone Number(s): (h) __________ (w)________________ (cell)________________

E-mail: ____

Race (check one)

Black African American ☐1
Black African ☐2
Black Caribbean/West Indian ☐3
White ☐4
Asian ☐5
☐6 __________

Ethnicity (check one)

Hispanic?
Yes ☐1
No ☐0

Place of Birth (check one)

U.S.A. ☐1
Africa ☐2
Caribbean/West Indies ☐3
Other ☐4 __________

If you were not born in the U.S. how long have you been in the U.S.? (check one)

Less than 1 year ☐1
1-5 years ☐2
More than 5 years ☐3

Age (check one)

Less than 18 ☐0
18 - 24 ☐1
25 - 39 ☐2
40 - 54 ☐3
55 - 64 ☐4
65 - 74 ☐5
75 or Older ☐6

Sex (check one)

Male ☐1
Female ☐2

Which of the following best describes your highest level of education? (check one)

Some high school ☐1
High school graduate/GED ☐2
Some college ☐3
Associate Degree ☐4
Bachelor's Degree ☐5
Advanced Degree ☐6

What is your current health insurance? (check one)

None ☐0
Medicaid ☐1
Private or through work ☐2
Medicare ☐3
Medicare and Private ☐4
Other ☐ 5 __________

Do you have diabetes? (check one)

Yes, Type 1 ☐1
Yes, Type 2 ☐2
Yes, not sure which type ☐3
Diagnosed with <u>Pre</u> Diabetes ☐4
No ☐0

If yes, when were you diagnosed with diabetes? (check one)

Less than 1 year ago ☐1
1 to 2 years ago ☐2
3 to 4 years ago ☐3
5 to 10 years ago ☐4
More than 10 years ago ☐5

Do you have a regular doctor?

Yes ☐ 1 No ☐0

Have you ever been to see a dietitian about diabetes?

Yes ☐1 No ☐0

Have you ever attended diabetes classes?

Yes ☐ 1 No ☐0

Have you attended <u>AAHP's diabetes classes within the past 2 years</u>?

Yes ☐1 No ☐0

How did you hear about AAHP diabetes classes? (check one)

Referred by AAHP Health Promoter ☐1 My friend/relative ☐2 A doctor/health provider ☐3
From the Internet ☐4 At church ☐ 5 From a sign that was posted ☐6 Newspaper ☐7 Other ☐8
Please give more specific info about **where or from whom** you heard about us: ____________________

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Class Behaviors Survey – Pre
For New People Only

Group - Reg #
_____-- _____

Location _________________ **First Name, Last Initial** ______________________________

1	**How many days a week do you get 30 minutes or more of physical activity that makes you break out into a sweat? (three 10 minute sessions or two 15 minutes sessions can count.)** 0 1 2 3 4 5 6 7
2	**About how many servings of fruits and vegetables do you eat each day?** (Each serving is about ½ cup.) Please circle your answer. 0 1 2 3 4 5 6 7 8 or more
3	**Has your doctor ever said that you have high blood pressure?** 1Yes 0 No **Are you taking medication for blood pressure?** 1Yes 0 No **Do you usually take your blood pressure medications as directed?** 1Yes 0 No **If not, why not?** ☐ 1- can't afford or too expensive ☐ 2- don't really know how or when to take ☐ 3- unpleasant side effects ☐ 4- can't remember to take regularly ☐ 5- other ____
4	**Do you smoke or use tobacco products? Yes No**

If you have diabetes, please continue to answer questions #5 – 8.

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For people with diabetes only.

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Please check the 1 statement that most closely matches how you feel.

When it comes to managing my blood sugar

0☐ I do not know how to handle most of my blood sugar problems

1☐ I know a little but I am not confident

2☐ I know some tips that I can try before calling my health care provider

3☐ I am confident that I know what to do for most blood sugar problems

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How often do you test your blood sugar? (Please circle your answer.)

Never 0 Once a day 1 2 times per day 2 3 times per day 3

4 times per day 4 Other ________________(please specify) 8

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How often do you check your feet?

0 Never 3 Every day 1 Once a week 2 Twice a week

8 Other (please specify) ____

8

Are you taking medication for blood sugar? 1Yes 0 No

Do you usually take your diabetes medications as directed? 1Yes 0 No

If not, why not?

☐ 1- can't afford or too expensive

☐ 2- don't really know how or when to take

☐ 3-unpleasant side effects

☐ 4- can't remember to take regularly

☐ 5- other ____

Many thanks for completing this survey!

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Diabetes Medical History Form

Name ___________________________ Phone ________________________
Email ___________________________ Date _________________________

****
****
For office use only: Staff Initial _______
Participant recommended for group class? □ Yes □ No Date ___________
****
****

General Information

What would you like to learn in these classes? _________________________________
____

Do you feel comfortable learning in a group class?	□ Yes □ No
Is there anyone who will help you in your diabetes care? If yes, who? _____________	□ Yes □ No

What is the main language spoken in your home? _____________

How do you rate your ability to read English? □ Very Good □ Good □ Not Good

Do you understand English well enough to be in the class without an interpreter?	□ Yes □ No
Do you have hearing or visual problems that will affect your learning in a group class?	□ Yes □ No
Do you follow any cultural or religious food restrictions or practices? If yes, ____	□ Yes □ No

Health Beliefs

How much of the managing of diabetes do you feel is in your hands?
□ Little of it □ Some of it □ Most of it

In your doctor's hands?
□ Little of it □ Some of it □ Most of it

Medication

If you take insulin:
Do you use a: □ syringe □ insulin pen □ insulin pump

What injection sites are used? ____

Where do you keep your insulin? _______________________________________

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Do you take diabetes medication? If yes, please list the amount and when you take it.

Name and Dose	When is your medication taken?

Do you take any over the counter medications or supplements?

Name and Dose	When do you take it?

Monitoring

What is your daily blood sugar normal range? ___________________________

Do you have a prescription for testing supplies?	□ Yes □ No

Hypoglycemia

Have you ever had a low blood sugar reaction?	□ Yes □ No
If yes, How did you treat it? ___________________________ How often has this occurred? ___________________________	
Do you carry a source of sugar with you?	□ Yes □ No
Have you ever had to be given glucagon?	□ Yes □ No

Diabetes Complications

Do you have any of the following medical problems?

Check if it applies			Check if it applies	
	Eye problems			Heart problems
	Kidney problems			Numbness/pain
	Sexual problems			Dental problems
	High cholesterol			Depression
	High blood pressure			

Please explain? ____

____

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In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless?	□ Yes □ No

Medical History

When was your last: physical ________________ eye exam _____________
dental exam ___________ foot exam _____________

What was your last A1c? _____________ date ____________ □ Don't Know

Have you ever been hospitalized with diabetes? If yes, how many times? _______________ When was the last time? ____________	□ Yes □ No
Have you been in the emergency department because of your diabetes? If yes, how many times? _______________ When was the last time? ____________	□ Yes □ No
Do you wear a medical identification bracelet or necklace?	□ Yes □ No
Have you ever had a Pneumonia vaccination?	□ Yes □ No
Have you received a Flu shot within the year?	□ Yes □ No

Please list any other information that you feel would be important for the AAHP to know.

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