

Chicago Southeast Diabetes Community Action Coalition

Form A.1

(Reviewed and Approved)

Diabetes Brief Intake Questionnaire



We would like to ask you some questions about your age, ethnic origin, education, height, weight, exercise habits, and diabetes risks. This information will be used to help us decide what services and information you may need. Your answers are confidential. This will only take a few minutes. Do you have any questions before we begin.

Place: _____ **Date:** _____

| | |
|---|---------------------------------|
| Ethnicity/Race: <input type="checkbox"/> 1. African-American <input type="checkbox"/> 2. Hispanic\Latino <input type="checkbox"/> 3. Asian <input type="checkbox"/> 4. Non-Hispanic White <input type="checkbox"/> 5. Other | |
| Age (years): | Sex: ? 1/Female ? 2/Male |
| Primary Language: <input type="checkbox"/> 1.English <input type="checkbox"/> 2.Spanish <input type="checkbox"/> 3. Other | Education (years): |

Have you ever been told by a health care provider that you have diabetes?

- 1 NO (If NO, complete only sections A and B)
- 2 YES (If Yes, complete sections A, B and C)

[FOR WOMEN] Are you pregnant now? Y N

First, we would like to find out whether you have access to and use certain health services.

| A. ACCESS AND PREVENTIVE CARE | | 1 | 2 |
|--|--|----------|----------|
| 1. Do you have a regular source of health care, that is, a doctor or clinic? | | Y | N |
| 2. In the past year, have you seen a doctor or health care provider for a medical checkup or physical exam? (IF NO, address issues and barriers.) | | Y | N |
| 3. Do you have health insurance, Medicaid, or Medicare? | | Y | N |
| 4. In the past year, have you had a blood sugar test? | | Y | N |
| 5. In the past year, has your blood pressure been taken? | | Y | N |
| 6. In the past year, have you had a blood cholesterol test? | | Y | N |
| 7. In the past year, have you had your teeth cleaned or checked? | | Y | N |
| WOME N ONLY | 8. In the past year, have you had a pap smear (cervical cancer exam)? | Y | N |
| | 9. In the past year, have you had a breast examination or mammogram? | Y | N |

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| B. DIABETES HEALTH RISK ASSESSMENT | Pts. |
|---|-------------|
| 1. AGE = SCORE: Under 45 = 0 points, 45-64 = 5pts 65 and older = 9pts | 5 9 |
| 2. Do you have a parent with diabetes? YES = 1 point, NO = 0 points | 1 |
| 3. Do you have a grandparent with diabetes? YES = 1 point, NO = 0 points | 1 |
| 4. Do you have a sibling with diabetes? YES = 1 point, NO = 0 points | 1 |
| 5. Have you done any exercise for at least 3 times a week in the past month? YES = 0 points, NO = 5 points | 5 |
| 6. Do you consider yourself to be overweight? YES = 3 points, NO = 0 points | 3 |
| 7a. What is your weight? Weight __ __ __ (Lbs.) 7b. What is your height? Height __ ' __ __ '' (feet/inches) BMI_____ % [SEE BMI CHART] BELOW/EQUAL/ABOVE? [SEE CONVERSION CHARTS] BMI over 25 = 5 points | 5 |
| 8. Did you weigh more than 9 pounds (4.1 kg) when you were born? YES = 1 point , NO = 0 points | 1 |
| 9. [WOMEN.] Have you had a baby weighing more than nine pounds at birth? YES = 6 points, NO = 0 points | 6 |
| 10. [WOMEN.] Did you ever have diabetes during a pregnancy? YES = 1 point, NO = 0 points | 1 |
| 11. Have you been told by a health provider that you have high blood pressure or hypertension? YES = 1 point, NO = 0 points | 1 |
| 12. Have you been told that you have high cholesterol levels? YES = 1 point, NO = 0 points | 1 |
| 13. Have you been told by a health care provider that you have heart disease? YES = 1 point, NO = 0 points | 1 |
| 14. Have you been told by a health care provider that your blood sugar is high or elevated, even if only intermittently? YES = 1 point, NO = 0 points | 1 |
| RISK SCORE: [If greater than 10 points, you are at high risk of diabetes.] Total | |

Recommendations : ? Blood Glucose Testing ? Brief Risk Reduction Counseling (WAAVE)
? Referral for Testing ? Health Education (specify) ? Referral to Healthcare Services ? Exercise Program

PLAN:

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| C. DIABETES CARE ASSESSMENT | Indicator |
|---|------------------|
| 1. Have you had diabetes for more than 1 year? IF YES, How many years? _ _ _ _ | Y N |
| 2. In the past year, how many times were you seen by a health care provider for diabetes? | — |
| 3. In the past year, how many times did you receive diabetes education? (No. of classes) | _ |
| 4. In the past year, how many times did you receive nutrition or meal planning education from a dietitian? | _ |
| 5. How many times a day do you check your blood glucose? | _ |
| 6. Have you heard of Glycosylated Hemoglobin or Hemoglobin A1C? | Y N DK |
| 7. In the past year, how many times was your Glycosylated Hemoglobin (A1c) checked? | 0 1 2 3 4 |
| *8. Do you have high blood pressure? | Y N DK |
| 9. If you have high blood pressure, are you receiving treatment? | Y N |
| *10. In the past year, have you had a blood cholesterol test? | Y N |
| 11. IF YES, Have you been diagnosed with high cholesterol? | Y N |
| 12. If you have high cholesterol, are you receiving treatment? | Y N |
| 13. In the past year, have you had a dilated eye exam? | Y N |
| 14. In the past year, how many times were your feet examined by a health care provider? | _ |
| 15. In the past year, have you had a flu shot? | Y N |

PLAN: ? Do IEP(Individual Education Plan) ? Diabetes Education ? Dietitian ? Eye Care ? Foot Care ? Dental Care ? Heart Care
? Other: