



Date: _____

Dear _____:

Diabetes Assessment Form

From your first Health Assessment you completed at enrollment, you stated that you have Diabetes. To ensure that you are properly managing your disease, please complete the following and return to us in the supplied envelope. These answers will help us determine your disease status.

If you received this form in error and don't have this disease, check the box below and return the form to us in the supplied envelope without answering any questions.

No, I don't have Diabetes.

1. How long have you been diagnosed with Diabetes?

(check one) Less than 1 year 1-5 years More than 10 years

2. Which type of medication do take for your Diabetes?

(check one) Pills only Insulin only Both pills and insulin None

3. If you take insulin, how often do you take it:

(check one) 1 time a day 2-3 times a day More than 3 times a day

4. How many times in the past year have you had to go to the hospital due to your diabetes?

(check one) 0 1 time 2-3 times More than 3 times

5. How often do you see your doctor about your diabetes?

(check one) 0 1 time a year 2 times a year 3 times a year or greater

6. How often do you have your HgbA1C checked?

(check one) 0 1 time a year 2 times a year Never Don't know what this is?

7. What was your last HgbA1C result?

(check one) 6.5 or less between 6.5 and 7.5 7.5 to 9.0 More than 9.0 Don't know

8. Do you have a glucometer (blood sugar testing device)? Yes No

9. How often do you check your blood sugar every day?

(check one) One time 2 times 3 times 4-5 times More than 5 times Never

10. What does your fasting (first one in the morning) blood sugar usually run?

(check one) 110 or less 110-120 120-140 More than 140 Don't know