OPTIMUM HealthCare, Inc.
P.O. Box 153178, Tampa, FL 33684
Health and Wellness Material

Diabetes Health Assessment Form

Date: _____

Name: _____

Address: _____

City:_____ State:_____ Zip: _____

DOB:_____ Age: _____ Gender: ____

Phone number: _____

Member ID:_____

Please complete the following assessment and return to us in the supplied envelope. These answers will help us determine your health status and ensure you are properly managing your health.

Have you been admitted to or been to a clinic at a VA (Veteran's Affairs) Hospital in the last 12 months? ❑ Yes ❑ No

If you received this form in error and don't have this health condition, check the box and return the form to us in the supplied envelope without answering any of the questions below. ❑ **No, I don't have Diabetes.**

1. Which type of medication do you take for your Diabetes?
(check one) ❑ Pills only ❑ Insulin only ❑ Both pills and insulin ❑ Other medicine by shot ❑ None

2. 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 ❑ On an insulin pump

3. 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 4 times

4. 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

5. How often do you have your blood HbA1c checked?
(check one) ❑ 0 ❑ 1 time a year ❑ 2 times a year ❑ Never ❑ Don't know what this is?

6. What was your last HbA1c result?
(check one) ❑ 6.5 or less ❑ Between 6.6 and 7.5 ❑ 7.6 to 9.0 ❑ More than 9.0 ❑ Don't know

7. Do you use a glucometer (blood sugar testing device)? ❑ Yes ❑ No

8. On a daily basis, how often do you check your blood sugar?
(check one) ❑ 1 time ❑ 2 times ❑ 3 times ❑ 4 times ❑ 5 times or more ❑ Never

9. What does your fasting (first one in the morning) blood sugar usually run?
(check one) ❑ 110 or less ❑ 111-120 ❑ 121-140 ❑ More than 140 ❑ Don't know

10. What does your blood sugar usually run if taken 2 hours after eating?
(check one) ❑ 110 -120 ❑ 121-140 ❑ 141-180 ❑ More than 180 ❑ Don't know

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Diabetes Health Assessment Form *(continued)*

11. During a week, how often does your blood sugar drop below 70?
(check one) ❑ Never ❑ 1 time a week ❑ 2 times a week ❑ 3 times or more a week ❑ Don't know

12. How do you change your diet in order to control your blood sugar?
(check one) ❑ Limit carbohydrate intake ❑ Limit sugar intake ❑ Don't follow a diet

13. When was the last time you attended Diabetes self management education classes?
(check one) ❑ Less than 1 year ago ❑ 1-2 years ago ❑ 3-5 years ago ❑ More than 5 years ❑ Never

14. Do you have any wounds that are not healing properly? ❑ Yes ❑ No

15. Do you have any of the following problems: (check all that apply)
❑ Cramping/pain in legs or buttocks after walking ❑ Pins/needles/burning to legs and/or feet
❑ Redness/swelling in legs ❑ Lack of feeling in fingers or toes

16. How often do you have your feet checked? ❑ 1 time a year ❑ 2 times a year ❑ Never

17. How often do you have a dilated eye exam? ❑ 1 time a year ❑ Never

18. How often do you have your urine checked? ❑ 1 time a year ❑ 2 times a year ❑ Never

19. How often do you exercise?
(check one) ❑ 1-2 days a week ❑ 3-4 days a week ❑ 5-7 days a week ❑ Not routinely

20. Do you take any medicine for high blood pressure? ❑ Yes ❑ No

21. Does your blood pressure usually run higher than 140/90? ❑ Yes ❑ No ❑ Don't know

22. Do you take any medicine for high cholesterol? ❑ Yes ❑ No

23. Do you take any medicine for chest pain? ❑ Yes ❑ No

24. If yes, has your chest pain been getting worse or more often? ❑ Yes ❑ No

25. Do you think your Diabetes has become better or worse over the past year?
(check one) ❑ Better ❑ Worse ❑ Stayed the same

26. How would you rate your ability to take care of yourself with the support you have in place?
(check one) ❑ Excellent ❑ Good ❑ Fair ❑ Poor

27. What is your living situation today? (check one)
❑ I have a steady place to live
❑ I have a place to live today, but I am worried about losing it in the future.
❑ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

28. Within the past 12 months, have you worried that your food would run out before you got money to buy more?
(check one) ❑ Often true ❑ Sometimes true ❑ Never true

29. In the past 12 months, has lack of reliable transportation kept you from medical appointment, meetings, work, or from getting things needed for daily living? ❑ Yes ❑ No