Pre/Post Class Feedback Form

Kentucky Diabetes Prevention and Control Program

Diabetes Self-Management Education/Training

Print Name: _____ Birth date: ___/___/___ Sex____ Race: ____
First Middle Last

Address: _____
Street Apt. # City ST Zip

Class Location: _____ Class dates: _____

This information will be used to evaluate the diabetes classes and is confidential.

1. What type of diabetes do you have? Check one ☑
   ☐type 1 ☐type 2 ☐pre-diabetes ☐don't know

2. Do you wear diabetes identification? ☐yes ☐no

3. Do you know what an A1c test is? ☐yes ☐no

4. Approximate date of last A1c test _____ Results, if known: _____

5. Do you take diabetes medicine(s)? ☐no ☐yes (if yes, check ☑all that apply):
   ☐insulin shots ☐Byetta shots ☐Symlin shots
   ☐diabetes pills ☐diabetes pills and shots

6. Do you ever miss a dose of your diabetes medicine(s)? ☐no ☐yes (if yes, ☑ all that apply):
   ☐ I cannot afford to buy my medicine
   ☐ I forget to take my medicine
   ☐ I don't like to take medicine

7. How many days in the past week did you exercise? **Circle one**: 0 1 2 3 4 5 6 7

8. On a day that you exercise, how many total minutes do you spend exercising?
   ☐ I do NOT exercise ☐ 30 minutes ☐ 60 minutes
   ☐ 15 minutes or less ☐ 45 minutes ☐ more than 60 minutes

9. Check ☑ all that apply to your eating habits:

   ☐ Follow a meal plan designed by a dietitian
   ☐ Use artificial sweeteners instead of sugar
   ☐ Eat 5 – 8 oz or less meat/meat substitute every day
   ☐ Read food labels
   ☐ Drink 6 to 8 (8 oz) glasses of water every day
   ☐ Eat 5 - 9 servings of fruits and vegetables every day
   ☐ Eat foods high in dietary fiber
   ☐ Count carbohydrates
   ☐ Limit amount and type of fat
   ☐ Do **not** follow a meal plan
   ☐ Count calories
   ☐ Eat at least 3 meals every day

10. Do you carry a source of sugar with you for treating a low blood sugar? ☐yes ☐no

11. What is your blood sugar goal? _____ before breakfast _____ 2 hours after eating

Please complete both sides of the feedback form.

This information is used to evaluate diabetes classes and is kept confidential.

12. Do you check your blood sugar? ☐ no ☐ yes (if yes, check ☑ how often):

☐ once a day	☐ once a week
☐ two times a day	☐ several times a week
☐ three times a day	☐ occasionally
☐ four times a day	☐ rarely or never

13. How often do you have blood sugar readings over 180?

☐ most days	☐ several times a month
☐ several times a week	☐ rarely or never

14. Do you have a sick day plan or know what to do when you get sick? ☐yes ☐ no

15. How often do you check your feet for sores, cuts, calluses, infection, or other problems?

☐ every day	☐ several times a month
☐ several times a week	☐ rarely or never

16. Do you have any of the following health problems or diabetes complications now?

☐ high blood pressure	☐ kidney problems
☐ stroke	☐ arthritis
☐ high cholesterol	☐ foot ulcers
☐ high triglycerides	☐ eye problems
☐ amputation (toe, foot, etc.)	☐ overweight
☐ pain/burning/loss of feeling in your feet	☐ digestive problems
☐ heart problems	☐ dental problems
☐ depression	☐ sexual problems

17. Do you use tobacco products? ☐ yes ☐ no I quit (date, if known) ___/___/___

18. Do you take an aspirin every day? ☐ yes ☐ no (if no, why not _____)

19. Have you ever had a Pneumonia shot? ☐ yes ☐ no ☐ don't know

20. Check ☑ the following procedures or tests that you have had in the last 12 months:

☐ dilated eye exam	☐ foot exam
☐ urine test for protein	☐ dental exam
☐ cholesterol test	☐ depression screening
☐ flu shot	☐ weight
☐ blood pressure	

Please complete both sides. Your feedback is important to us.

Thank you.