Pre/Post Class Feedback Form
Kentucky Diabetes Prevention and Control Program
Diabetes Self-Management Education/Training

Print Name: ____________________________________ Birth date: ___/___/___ Sex____ Race: ____

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

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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.

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