GATEWAY COMMUNITY HEALTH CENTER, INC.

Diabetes Self Management Project

Registration Form

Name:_____ D.O.B.:_____/_____/_____ MF#:_____

Address:_____ Phone Number:_____

☐ Male ☐ Female ☐ English ☐ Spanish _____
Sex Language Occupation

_____
Highest Grade Completed

Average Family Income in Thousands	-5	5-10	11-14	20-24	+25

I have had the following checked diseases. My parents or grandparents have had the diseases circled:
Diabetes_____ Heart_____ Cancer_____ Hypertension_____

If you have diabetes, how many years have you had diabetes? _____

In the past year, have you visited the hospital or emergency room? ☐ Yes ☐ No
Hospital _____ Emergency Room_____. How long was your stay***?***_____

Do you know your normal sugar level? ☐ ***Yes*** ☐ ***No***_____

Do you know your normal blood pressure? ☐ ***Yes*** ☐ ***No***_____

Do you smoke? ☐ ***Yes*** ☐ ***No***

Do you exercise? ☐ ***Yes*** ☐ ***No***
If yes, what type of exercise? _____
How many times per week? _____
For how long? _____

Do you experience some of the following stress symptoms? If yes, please check.

Headache_____ Indigestion_____ Backache_____ Stiffness of neck_____ Nervousness_____
Dizziness_____ Anxiety_____ Depression_____ Boredom_____ Trouble sleeping_____ Other_____

Please provide a second phone number, where we can reach you.

_____ _____
Name/Relationship Phone Number

This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX with support from the Robert Wood Johnson Foundation ® in Princeton, NJ.

Interviewer: _____ Date:_____ Location:_____

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