NAME: _____ PFH # _____

My Diabetes / Hypertension Action Plan Assessment

1. I have been seen in the Emergency Room or hospitalized because of problems with my diabetes or hypertension in the past 12 months. Yes ____ No ____
2. I feel my control over my diabetes / high blood pressure is:
    a. Excellent ____ Good _____ Fair _____ Don't Know _____
3. I feel I will benefit from a self – management program:
    a. Yes _____ No _____
4. I know the results of my:
    a. Blood Sugar _____ HgbA1c _____ Blood Pressure _____
5. I am doing well with:
    a. Exercising Yes ___ No ___
        i. Which activity? _____; How often / week? _____
    b. Food Choices Yes ___ No ___
    c. Taking medications as ordered Yes ___ No ___
    d. Know the side effects of my medications Yes ___ No ___
    e. Monitoring my blood sugar / high blood pressure as needed Yes ___ No ___
    f. Managing Stress Yes ___ No ___
    g. Others _____ Yes ___ No ___
6. I want to do better with my: (please circle)
    a. Exercising
    b. Diet
    c. Use of Medication
    d. Monitoring my blood sugar / high blood pressure
    e. Managing stress
    f. Smoking
    g. Other _____
7. To improve my health, I want to work on improving at least ONE aspect of my diabetes / hypertension.
    a. This is what I'll do: _____
    b. How Much: _____
    c. When: _____
    d. How Often: _____
8. After talking with my medical provider, I feel I can better manage my chronic condition:
    a. Yes ____ No ____

DO NOT WRITE BELOW THIS LINE _____

Date	Blood Sugar	HgbA1c	Blood Pressure

(Goals: HgbA1c less than or equal to 7, Blood Pressure less than or equal to 140 / 80)