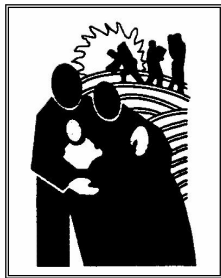


This product was developed by the diabetes self management project at Gateway Community Health Center, Inc. in Laredo, TX. Support for this product was provided by a grant from the Robert Wood Johnson Foundation® in Princeton, New Jersey.



# GATEWAY COMMUNITY HEALTH CENTER, INC.

## Diabetes Self Management Project

### Registration Form

Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ MF#: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Male  Female

Sex

English  Spanish

Language

Occupation \_\_\_\_\_

\_\_\_\_\_  
Highest Grade Completed

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

**Interviewer:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Location:** \_\_\_\_\_