**Today’s Date** *(mm/dd/yyyy)***: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Name:** | **Age:** |
| **E-mail Address**:  **Preferred Phone Number**:  \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_  **Do you prefer texting**? \_\_ Yes \_\_ No  If so, provide your cell number  \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ | **Who is the primary payer for your participation in this National DPP Lifestyle Change Program? (Choose one)**  \_\_\_ Medicare \_\_\_ Dual eligible  \_\_\_ Medicaid \_\_\_ Grant Funding  \_\_\_ Private Insurer \_\_\_ Employer  \_\_\_ Self-pay \_\_\_ Free of charge  \_\_\_ Other |
| **Who or What *motivated* you the most to sign up for this program; what was the most influential factor? Check one**  \_\_\_ Healthcare professional  \_\_\_ Blood test result  \_\_\_ Prediabetes risk test  \_\_\_ Someone at community-based organization (church, community center, fitness center)  \_\_\_ Family/friends  \_\_\_ Current or past participant in National DPP LCP  \_\_\_ Employer or employer’s wellness plan  \_\_\_Health insurance plan  \_\_\_ Media advertisement (social media, flyer, brochure, radio ad, billboard, newspaper ad) | **Did a healthcare professional ask you to join the program?**  \_\_\_ Yes, a doctor/doctor’s office  \_\_\_ Yes, a pharmacist  \_\_\_ Yes, other healthcare professional  \_\_\_ No  **What is your highest education level?**  \_\_\_ Less than grade 12 (no high school diploma or GED)  \_\_\_ Grad 12 or GED  \_\_\_ Some college or technical school  \_\_\_ College or technical school graduate or higher |
| **Sex**  What sex were you assigned at birth?  \_\_\_ Male \_\_\_\_ Female  \_\_\_ Do not wish to report | **Gender** What genderidentity do you most identify with?, (check one)  \_\_\_ Male \_\_\_\_ Female  \_\_\_\_ Transgender \_\_\_ Do not wish to report |
| **Race** (*check all that apply):*  \_\_\_\_\_ American Indian or Alaska Native  \_\_\_\_\_ Asian or Asian American  \_\_\_\_\_ Black or African American  \_\_\_\_\_ Native Hawaiian or Pacific Islander  \_\_\_\_\_ White | **Ethnicity** (*check one*):  ⎯⎯⎯ Hispanic or Latino  \_\_\_\_\_\_ Not Hispanic or Latino |
| **Height:**  \_\_\_\_\_\_ feet \_\_\_\_\_\_ inches | **Weight***:*  *\_\_\_\_\_\_\_\_* pounds *(round to nearest pound)* |

**Have you been told by a health care provider that you have prediabetes, elevated blood sugar,   
or borderline diabetes?** *(check one*):

\_\_\_\_\_ Yes \_\_\_\_\_ No

**\* If yes*,* what type of blood test was performed?** *(check all that apply)*

\_\_\_\_\_ Finger prick blood test

\_\_\_\_\_ Fasting glucose test (blood test where blood was drawn with needle)

\_\_\_\_\_ Hemoglobin A1c test

\_\_\_\_\_ Oral Glucose Tolerance Test

\_\_\_\_\_ Don’t know / don’t remember

**\* Please include a copy of your lab result with this form, if possible.**

**If you are a woman, have you ever been told by a health care provider that you had Gestational Diabetes Mellitus (GDM) during pregnancy?** *(check one*):

\_\_\_\_\_ Yes \_\_\_\_\_ No