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 gender identity 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

*** <u>If yes</u>, 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.**

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

______ Yes ______ No