Van Buren County Hospital
Simply Remarkable
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DIABETES PATIENT QUESTIONNAIRE

Name: _____ Date: _____
Date of Birth: _____ Sex: Female ☐ Male ☐

Address (Street, City, State, Zip Code):_____

Phone Number(s): _____ _____ _____
(Cell) (Home) (Work)

E-Mail address (optional) _____

Primary Care Provider:_____ Endocrinologist (if applicable):_____

How long have you known that you have diabetes? _____

Have you attended diabetes classes before?

☐ No ☐Yes (Date and Place): _____

Do you have a family history of diabetes?

☐No ☐Yes (Whom?): _____

Do you test your blood sugar levels at home?

☐ No (reason): _____

☐Yes Please √ number of times you test each day:

☐One ☐Two ☐Three ☐Four ☐Five or more

When do you test? (√ all that apply):

☐Before breakfast ☐Before lunch/ dinner ☐After meals

☐At bedtime Other: _____

Do you ever have *LOW* blood sugar levels?

☐No ☐Yes ☐I don't know

If yes, please √ how often: ☐Daily ☐Weekly ☐Monthly ☐Other: _____

What time(s) of day do most of your low blood sugars occur? (Please √ all that apply)

☐Morning ☐Mid-Day ☐ Afternoon ☐ Evening ☐Night

How do you treat low blood sugars? _____

Have you ever lost consciousness or required assistance to reverse low blood sugar?

☐No ☐Yes When did it occur last? How often has it occurred? _____

Do you ever have *HIGH* blood sugar levels?

☐No ☐Yes ☐I don't know

If yes, please √ how often: ☐Daily ☐Weekly ☐Monthly ☐Other: _____

What time(s) of day do most of your high blood sugars occur? (please √ all that apply)

☐Morning ☐Mid Day ☐ Afternoon ☐ Evening ☐Night

How do you treat high blood sugars? _____

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Do you have any other health problems?

□No □Yes (√): □High Blood Pressure □ Heart Disease □High Cholesterol/Triglycerides
□Glaucoma □Stroke □ Retinopathy (EYE)
□Kidney Problems □Asthma □Neuropathy (NERVE)
□Organ transplant □Thyroid □Teeth or Gums
Other: _____

Do you have any of the following problems?

Vision □No □Yes Can you see well with glasses? □No □ Yes
Hearing □No □Yes Do you wear a hearing aide? □ No □Yes

Do you take pills for your diabetes?

□No □Yes

Do you take insulin?

□No □Yes

Do you use an insulin pump?

□No □Yes

How often do you see your doctor?

□Monthly □Every 3 months □Every 6 months □Annually □Every few years □Never

When did you see your *EYE* doctor last? Date:_____

Do you live alone?

□Yes □No (Whom do you live with?): _____

Do you smoke?

□ No □Yes □Former Smoker

Do you drink alcohol?

□No □Yes:
□Beer □Wine □Liquor
Amount/Frequency:_____

Do you work?

□Yes □ No
□ Retired □Unemployed
If yes, what shift do you work? □Days □Evenings □Nights □Rotating

What are your usual work hours? _____

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Having diabetes makes me…. (√ all that apply to you)

□Angry □ Afraid □Confused □Sad □Upset
□ Feel like I can't do my job
□Feel like I can't live the way I want
□Feel like I am a sick person
□Feel like I should eat better
□Other: _____

Is there much *STRESS* in your life? □No □Yes
What do you do to handle stress in your life? _____
_____

Do you ever get *DEPRESSED?* □No □Yes
How often?: □ A lot □ Sometimes □ Rarely

Do you exercise?

□ No □Yes (√) Favorite type: □Walking □Aerobics/Dance □Elliptical Machine
□Swimming □Jogging/Treadmill □Weight Lifting
□Cycling/Stationary Bike □ Other_____

(√) How often: □Daily □1 to 2 x/week □ 3 to 4 x/week □5 to 6 x/week
□7 x/week or more

(√) Length of workout: □1-10 minutes □11-20 minutes □21-30 minutes
□31-45 minutes □60 minutes □Other:_____

Do you have any limitations on exercise?

□No □Yes, please describe: _____

Have you had previous instruction on diet?

□**Yes** □**No**

Do you have a meal plan? □No □Yes If yes, how many calories?_____

How much of the time are you able to follow it? □0%-25% □25%-50%
□50%-75% □75%-100%

Do you follow any dietary restrictions or special meals?

□No □Yes (√) □ Vegetarian □Vegan
□ Low Carbohydrates
□ Low Fat / Cholesterol
□ Low salt
□ Other: _____

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How is your *APPETITE?* □Good □Fair □Poor

Do you take vitamins or any other nutrition supplements?

□No □Yes

□Multivitamins:_____ □ Calcium □Vitamin E □Niacin
□ Chromium □Vitamin B-6 □Potassium □ Iron
□Vitamin D □ Selenium □ Folic acid □Vitamin B12

What eating concerns do you have? _____

What would you like to know more about?

□ Weight loss □ Diet □ Alcohol consumption □Exercise □ Label reading
□ Other

_____

What do you hope to accomplish or gain from this Population Health Program?

I would like to:

□ Improve blood sugar □ Improve eating habits □ Lose weight
□ Improve exercising □ Lower cholesterol/triglycerides □ Lower blood pressure
Other: _____

<u>Evaluation of Questionnaire</u> (Optional but greatly appreciated)

How long did it take to complete this questionnaire? : _____Minutes

Do you find this questionnaire to be:

	Agree (√)	Disagree (√)
Understandable		
Legible		
Enough Space to Write		
Too Long		

Did you receive your questionnaire at home?

□No □Yes: How long before the program did you receive your questionnaire?

□ 1 week □ 2 weeks □ 3 weeks □ 4 weeks □ Other: _____

Additional Comments/Feedback: