

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 \checkmark number of times you test each day:
 One Two Three Four Five or more

When do you test? (\checkmark 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 \checkmark how often: Daily Weekly Monthly Other: _____

What time(s) of day do most of your low blood sugars occur? (Please \checkmark 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?

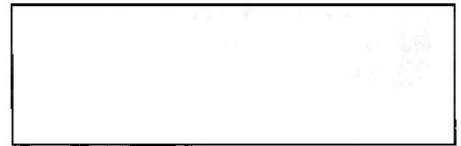
No Yes I don't know

If yes, please \checkmark how often: Daily Weekly Monthly Other: _____

What time(s) of day do most of your high blood sugars occur? (please \checkmark 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: _____

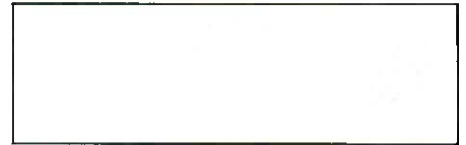
Do you work?

- Yes No

- Retired Unemployed

If yes, what shift do you work? Days Evenings Nights Rotating

What are your usual work hours? _____



DIABETES PATIENT QUESTIONNAIRE

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: _____



DIABETES PATIENT QUESTIONNAIRE

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, salt substitute 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: _____

Evaluation of Questionnaire (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:
