SAMPLE QUESTIONNAIRE

DIABETES

You may use all or parts of the questionnaire at no charge without permission

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Palo Alto CA 94304
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http://patienteducation.stanford.edu
self-management@stanford.edu
Name: ___________________________________________   Today's date: __________________________
Address: _____________________________________________________________
City, state, zip: ________________________________________________________
Telephone: home (____) ______ - ____________    Date of birth: __________________________
     work (____) ______ - ____________    Sex:  □ Female   □ Male

Background

1. Ethnic origin (check only one):
   □ White not Hispanic   □ Asian or Pacific Islander
   □ Black not Hispanic   □ Filipino
   □ Hispanic            □ American Indian/Alaskan Native
   □ Other: __________________________

2. Please circle the highest year of school completed:


1  2  3  4  5  6   7  8  9  10  11  12   13  14  15  16   17  18  19  20  21  22   23+
( primary)                      ( high school)   ( college/university)   ( graduate school)

3. Are you currently (check only one):
   □ married   □ separated   □ widowed
   □ single    □ divorced

4. Please indicate below which chronic condition(s) you have:
   □ Diabetes type 2   □ Diabetes type 1   □ High cholesterol   □ High blood pressure
   □ Heart disease   Type of heart disease: ________________________________
   □ Lung disease    Type of lung disease: ________________________________
   □ Other chronic condition Specify:____________________________________________
General Health

1. In general, would you say your health is:

   (Circle one)
   Excellent ..................................1
   Very good.................................2
   Good.......................................3
   Fair.......................................4
   Poor.......................................5

Symptoms

How much time during the past month...

<table>
<thead>
<tr>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A good bit of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
</table>

1. Were you discouraged by your health problems? .....................................0 1 2 3 4 5
2. Were you fearful about your future health? ..........................................0 1 2 3 4 5
3. Was your health a worry in your life? ....0 1 2 3 4 5
4. Were you frustrated by your health problems? .....................................0 1 2 3 4 5

5. We are interested in learning whether or not you are affected by fatigue. Please circle the number below that describes your fatigue in the past 2 weeks:

   ![Fatigue Scale](image)
6. We are interested in learning whether or not you are affected by pain. Please circle the number below that describes your pain in the past 2 weeks.

7. We are interested in learning whether or not you are affected by shortness of breath. Please circle the number below that describes your shortness of breath in the past 2 weeks:

In the PAST WEEK, did you ever have any of the following symptoms…

8. Increased thirst? ................................................................. ☐ No ☐ Yes ☐ Don’t know

9. Dry mouth? ................................................................. ☐ No ☐ Yes ☐ Don’t know

10. Decreased appetite? ................................................................. ☐ No ☐ Yes ☐ Don’t know

11. Nausea or vomiting? ................................................................. ☐ No ☐ Yes ☐ Don’t know

12. Abdominal pain? ................................................................. ☐ No ☐ Yes ☐ Don’t know

13. Frequent urination at night? Do you have to get up to urinate 3 or more times a night? ................. ☐ No ☐ Yes ☐ Don’t know

14. Severely high blood sugar (blood glucose readings of 300 mg or higher?) …......................... ☐ No ☐ Yes ☐ Don’t know

15. Morning headaches? ................................................................. ☐ No ☐ Yes ☐ Don’t know
In the PAST WEEK, did you ever have any of the following symptoms…


17. Night sweats? ....................................................................................[ ] No  [ ] Yes  [ ] Don’t know

14. Lightheadedness? ............................................................................[ ] No  [ ] Yes  [ ] Don’t know

18. Shakiness or weakness? ...................................................................[ ] No  [ ] Yes  [ ] Don’t know

19. Intense hunger? ................................................................................[ ] No  [ ] Yes  [ ] Don’t know

20. Times when you passed out fainted or lost consciousness, even for a short time? [ ] No  [ ] Yes  [ ] Don’t know

### Daily Activities

During the **past 4 weeks**, how much...

<table>
<thead>
<tr>
<th>(Circle one)</th>
<th>Not at all</th>
<th>Slightly</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Almost totally</th>
</tr>
</thead>
</table>

1. Has your health interfered with your normal social activities with family, friends, neighbors or groups? ..................0 1 2 3 4

2. Has your health interfered with your hobbies or recreational activities? ............0 1 2 3 4

3. Has your health interfered with your household chores? ..................0 1 2 3 4

4. Has your health interfered with your errands and shopping? ..................0 1 2 3 4

### Your Glucose Testing

1. Do you have a machine to measure your blood sugar (glucose) level?  [ ] Yes  [ ] No

2. On how many days in the **last week** did you test your blood sugar level? *(If you were sick in the last week, think of the most recent 7 days when you were NOT sick)*

   ________ days

3. On **days** that you test your blood sugar, how many **times** do you test on average?  ________ times
**Physical Activities**

**During the past week**, even if it was not a typical week for you, how much **total** time (**for the entire week**) did you spend on each of the following? *(Please circle one number for each question.)*

<table>
<thead>
<tr>
<th></th>
<th>none</th>
<th>less than 30 min/wk</th>
<th>30-60 min/wk</th>
<th>1-3 hrs per week</th>
<th>more than 3 hrs/wk</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Stretching or strengthening exercises</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(range of motion, using weights, etc.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Walk for exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. Swimming or aquatic exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. Bicycling (including stationary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>exercise bikes)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. Other aerobic exercise equipment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Stairmaster, rowing, skiing machine, etc.)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. Other aerobic exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specify_______________________________</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

**Confidence About Doing Things**

For each of the following questions, please **circle** the number that corresponds with your **confidence** that you can do the tasks regularly at the present time.

1. **How confident** do you feel that you can eat your meals every 4 to 5 hours every day, including breakfast every day?
   - Not at all  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very confident

2. **How confident** do you feel that you can follow your diet when you have to prepare or share food with other people who do not have diabetes?
   - Not at all  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very confident

3. **How confident** do you feel that you can chose the appropriate foods to eat when you are hungry (for example, snacks)?
   - Not at all  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very confident

4. **How confident** do you feel that you can exercise 15 to 30 minutes, 4 to 5 times a week?
   - Not at all  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very confident

5. **How confident** do you feel that you can do something to prevent your blood sugar level from dropping when you exercise?
   - Not at all  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Very confident

6. **How confident** do you feel that you know what
to do when your blood sugar level goes higher or lower than it should be?

7. **How confident** do you feel that you can judge when the changes in your illness mean you should visit the doctor?

<table>
<thead>
<tr>
<th>Not at all confident</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very confident</th>
</tr>
</thead>
</table>

8. **How confident** do you feel that you can control your diabetes so that it does not interfere with the things you want to do?

<table>
<thead>
<tr>
<th>Not at all confident</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Very confident</th>
</tr>
</thead>
</table>

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**Your Diet**

1. How many **times last week** did you eat breakfast when you got up? _______ times last week

2. **This morning**, did you eat any of the following foods for breakfast? *(Please check all that apply)*
   - [ ] milk (½ cup)
   - [ ] cheese
   - [ ] yogurt
   - [ ] eggs
   - [ ] meat, poultry, or fish
   - [ ] beans

   If you ate anything else, please write here: _________________________________________

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**Medications**

1. In the past week did you take pills for diabetes? .................[ ] No [ ] Yes [ ] Don’t know

   Please specify the name(s) of the diabetes pills you took: ______________________________

2. In the past week did you get insulin injections? .................[ ] No [ ] Yes [ ] Don’t know

3. In the past week did you take pills for high blood pressure? .........................................................[ ] No [ ] Yes [ ] Don’t know

   Please specify the name(s) of the blood pressure pills you took: __________________________

4. In the past week did you take pills for cholesterol? ..........[ ] No [ ] Yes [ ] Don’t know

   Please specify the name(s) of the cholesterol pills you took: _____________________________
Medical Care

1. When you visit your doctor, how often do you do the following (please circle one number for each question):

   a. Prepare a list of questions for your doctor ........................................0 1 2 3 4 5
   b. Ask questions about the things you want to know and things you don’t understand about your treatment........0 1 2 3 4 5
   c. Discuss any personal problems that may be related to your illness .................0 1 2 3 4 5

2. In the past 6 months, how many times did you visit a physician? Do not include visits while in the hospital or the hospital emergency department...__________ visits

3. In the past 6 months, how many times did you go to a hospital emergency department? ............................................................................__________ times

4. In the past 6 months, how many TIMES were you hospitalized for one night or longer? .............................................................................................__________ times
   a. How many total NIGHTS did you spend in the hospital in the past 6 months? ....................................................................................................__________ nights
   b. Were any of these hospitalizations at a skilled nursing facility, convalescent hospital, or other minimum care facility? ...........................□ Yes □ No

5. When was the last time you had your eyes examined? (example: for glaucoma or any other problem) .................................................._____________ Month Year

6. How many times did the doctor or nurse examine your feet in the last 6 months? ..........................................................................................__________ times

Thank you for your help!