

Today's Date is : ____ / ____ / ____
month day year
 104.49

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Self-Administered <input type="checkbox"/>	Patient with no help <input type="checkbox"/>
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	Other <input type="checkbox"/>

101.1

104.50

Patient ID | | | | | | | | | |

Physician ID | | | | | | | |

Clinic/Site ID | | | | | | | | | |

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Patient Questionnaire

DIABETES FORM 2.1

TO BE COMPLETED BY PATIENT

Original by Byron Hoogwerf, M.D.
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INSTRUCTIONS:

This survey asks for your views about symptoms that frequently occur with diabetes. This information will be summarized in your medical record and will help your doctors keep track of how you feel.

Answer every question by circling the appropriate number. If you are unsure about how to answer a question, please give the best answer you can.

1. How often have you had any of the following symptoms during the past four weeks? (circle one number in each row)

	Never	Once or twice	A few times	Fairly often	Very often
a. Feeling of fullness or nausea two hours after eating	1	2	3	4	5
b. Headaches or head pains	1	2	3	4	5
c. Feeling drowsy or sedated	1	2	3	4	5
d. Feeling dizzy when getting up	1	2	3	4	5
e. Feeling lightheaded or unsteady while on your feet	1	2	3	4	5
f. Weakness, dizziness, heart pounding, or tremors that are relieved by eating	1	2	3	4	5
g. Shortness of breath when lying down flat	1	2	3	4	5
h. Chest discomfort/pain brought on by activity	1	2	3	4	5
i. Chest discomfort/pain relieved by rest	1	2	3	4	5
j. Pins and needles, pain, numbness, or burning in your feet	1	2	3	4	5
k. Urinating more than usual	1	2	3	4	5
l. Getting up at night several times to urinate	1	2	3	4	5
m. Losing urine involuntarily	1	2	3	4	5
n. Confusion or disorientation relieved by eating	1	2	3	4	5
o. Diarrhea during the night / involuntary loss of stools	1	2	3	4	5

104.124

2. Please indicate how much you agree with each statement below based on your experiences during the past four weeks: (circle one number in each row)

	Strongly agree	Agree	Disagree	Strongly disagree	N/A
a. I find sugar monitoring painful	1	2	3	4	5
b. I think taking medication or insulin is a waste of time	1	2	3	4	5
c. I find testing blood sugars difficult	1	2	3	4	5

104.125

3. During the past four weeks, how often has your vision interfered with your ability to do the following (circle one number in each row)

104.126

	Never	Once or twice	A few times	Fairly often	Very often
a. Read	1	2	3	4	5
b. Drive a car	1	2	3	4	5
c. Watch television	1	2	3	4	5

4. During the past four weeks, to what extent have you experienced problems with sexual function? (circle one number)

104.127

	Never	Once or twice	A few times	Fairly often	Very often
	1	2	3	4	5

5. During the past four weeks, how much of the time has leg discomfort limited your ability to do the following: (circle one number in each row)

104.128

	Never	Once or twice	A few times	Fairly often	Very often
a. Perform activities around the house	1	2	3	4	5
b. Wear the shoes you wanted	1	2	3	4	5
c. Sleep	1	2	3	4	5

6. During the past four weeks, how much has your need to follow a special diet interfered with your social life? (circle one number)

100.1380

	Never	Once or twice	A few times	Fairly often	Very often
	1	2	3	4	5

7. How frequently have you had hypoglycemic symptoms (low sugar reaction) because of your inability to eat according to a regular schedule? (circle one number)

100.1381

	1	2	3	4	5
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8. How many times do you check your blood sugar in an average week? ____ ____ 104.129

9. During the last 12 months: 104.130

- a. How many times did you go to the emergency room or urgent care facility for any reason? ____
- b. How many times were you seen in a doctor's office for any reason? ____
- c. How many nights did you spend in the hospital? ____
- d. How many times did you receive diet counseling? ____
- e. How many times have you seen a diabetes educator? ____