

Diabetes Questionnaire

Name: _____

Date Completed: _____

Member #: _____

Date of Birth: _____

Thank you for taking the time to complete this questionnaire. Your answers are important and will help us to meet your health care needs. This questionnaire will take about 10 minutes to finish.

General Information

- What is your address and best contact telephone number?
 _____ (Address) (City, State, Zip code) () _____ (Phone number)
- Do you live: alone spouse or partner
 (please check all that apply) parent/guardian other non-family members
- What is your primary language? Do you need an interpreter? Yes No Don't know
- What is the name of the doctor or care provider you see most? _____
 Clinic Name/Address: _____ Phone: () _____

General Health Information

- Are you experiencing any pain at this time? Yes No Don't know
 If yes, where? _____
 On a scale of "0" to "10" how would you rate your pain?
 (where "0" is no pain, "5" is moderate pain, and "10" is the worst pain you've ever had)
 0 1 2 3 4 5 6 7 8 9 10
- In the past few weeks, have you felt down, depressed or hopeless? Yes No Don't know
 If yes, please explain: _____
- In the past 2 weeks, have you lost interest in doing things you have enjoyed in the past? Yes No Don't know

- Have you had a flu shot? Yes No Don't know
 If yes, what was the date of your last shot? _____
- Have you had a pneumonia shot? Yes No Don't know
 If yes, what was the date of your last pneumonia shot? _____
- Are there any other medical problems you are being treated for? Yes No Don't know
 If yes, please explain: _____
- In the last 6 months, have you been to the emergency room (ER) for diabetes? If yes, how many times? Yes No Don't know

- What are your health goals and interests? Eating better Reducing stress Losing weight
 Exercising Aging well Other

Medication Information

13. What prescription medications do you take?
Please list: _____
14. Do you take non-prescription medications or supplements (for example, aspirin, vitamins, etc.)? If yes, please list: _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
15. Have you been taking your medications as prescribed by your doctor?
If no, why not? _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
16. Are you having any problems taking your medications?
If yes, please explain: _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Diabetes Information

17. How many times a day do you check your blood sugar? _____
What is your average fasting blood sugar? _____
18. Do you know what your hemoglobin A1c (HbA1c) score is? _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, what is it? ____ % When was your last HbA1c taken? _____
(This blood test measures blood sugars over a longer period of time. Checked every 3-6 months.)
19. In the last 12 months, did you have your cholesterol checked? _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, do you know what your LDL (bad cholesterol) level is? _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, what is it? _____
20. In the last 12 months, did you have a blood test called a serum creatinine?
(This is a blood test that measures how well your kidneys are working.)
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
21. In the last 12 months, did you have a blood test to check your potassium level?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
22. In the last 12 months, did you have a urine test for albumin or protein?
(This test looks for proteins that may be an early sign of kidney problems.)
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
23. In the last 12 months, did you have an eye exam where the doctor put drops in your eyes?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
24. Do you check your feet every day?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
25. In the last 12 months, did your doctor examine your feet?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
26. Do you know your blood pressure? If yes, what is it? _____/_____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
27. Do you have a written Diabetes Sick Day Plan?
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
28. Does your diabetes affect your ability to perform your usual daily activities? If yes, How? _____
- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't know |
| | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Diabetes Questionnaire



Additional Information							
29. Would you like to participate in our diabetes educational program?	Yes	No	Don't know				
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
(This is a free benefit that is offered by Community Health Plan of WA. No classes or travel are required. A nurse will call you on the telephone)							
30. What days are best to call you?	Mon	Tue	Wed	Thu	Fri	Any Day	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
What are the best times to call you?	<input type="checkbox"/> 7-9 am	<input type="checkbox"/> 9-11 am	<input type="checkbox"/> 11 am-1 pm				
	<input type="checkbox"/> 1-3 pm	<input type="checkbox"/> 3-5 pm	<input type="checkbox"/> Anytime				
31. Is there anything else we can do to help you?							

Thank you for answering these questions.

Please return this completed form in the self-addressed, stamped envelope provided and one of our Disease Management Nurses will contact you. As part of this program, we will mail educational materials to you to help you manage your diabetes.