

Additional Information

38. Would you like to speak with one of our health educators about any specific health concerns you have? Yes No Don't know

Which days are best for you? Mon Tue Wed Thu Fri Any Day

What are the best times to reach you? 7-9 am 3-5 pm
 9-11 am 5-7 pm
 11 am-1 pm After 7 pm
 1-3 pm Anytime

39. Would you like to participate in our diabetes educational program? (This is a free benefit that is offered by Community Health Plan. No classes or travel are required.) Yes No Don't know

40. Is there anything else I can help you with today?

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

Date completed: _____

Member name: <First name Last name> _____ Member ID: <#> _____

Date of birth: <date> _____ Gender: M F

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 15 minutes to finish.

General Information

1. Did you receive a Welcome Letter with information from Community Health Plan? Yes No Don't know

2. Do you have a new address and phone number? Yes No
 If yes, what are your new address and phone number?

 (Phone number)

 (Address) (City, State Zip code)

3. Do you live: Alone With son or daughter
 (please check all that apply) With spouse or partner With other family members
 With parent/guardian With friend or other non-family members

4. What is your primary language? _____ Do you need an interpreter? Yes No Don't know

Care Provider Information

5. What is the name of the doctor or care provider you see most? _____

6. Do you feel comfortable contacting your doctor or care provider if you are experiencing pain or discomfort? Please explain: Yes No Don't know

7. Do you have any questions or concerns about diabetes that you wish to discuss with your doctor or care provider? Please explain: Yes No Don't know

8. Do you have any questions you feel uncomfortable asking your doctor or care provider? Please explain: Yes No Don't know

9. Are you satisfied with your plan for care? Please explain: Yes No Don't know

General Health Information				
10. How would you describe your health in general?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
11. How would you rate your physical activity level?	Active <input type="checkbox"/>	Moderate <input type="checkbox"/>	Light <input type="checkbox"/>	Sedentary <input type="checkbox"/>
12. Are you experiencing any pain at this time? If yes, where in your body? _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
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			
13. In the past few weeks, have you felt down, depressed or hopeless? If yes, please explain: _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
14. Have you had a flu shot? If yes, what was the date of your last flu shot? _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
15. Have you had a pneumonia shot? If yes, what was the date of your last pneumonia shot? _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
16. In the last 6 months, have you been to the emergency room (ER) or hospital for diabetes? If yes, how many times? _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
17. Is there a chance you could be pregnant? If yes, are you enrolled in our New Arrivals Program?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
18. Do you have any health concerns or other medical problems you would like to talk about? If yes, please explain: _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
19. What are your health goals and interests?	<input type="checkbox"/> Eating better	<input type="checkbox"/> Reducing stress		
	<input type="checkbox"/> Exercising	<input type="checkbox"/> Medical conditions		
	<input type="checkbox"/> Losing weight	<input type="checkbox"/> Aging well		

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

Diabetes Information				
24. How many times do you check your blood sugar every day? _____ What is your average fasting blood sugar? _____				
25. Do you know what your hemoglobin A1c (HbA1c) score is? If yes, what is it? _____% When was your last HbA1c taken? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
<i>(This is a blood test that gives a more accurate measure of your blood sugars over a longer period of time. It is usually checked every 3-6 months.)</i>				
26. In the last 12 months, have you had an eye exam where the doctor put drops in your eyes? When was your last eye exam: <input type="checkbox"/> 0-3 months <input type="checkbox"/> 3-6 months <input type="checkbox"/> more than 6 months <input type="checkbox"/> Don't know	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
27. Do you check your feet every day?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
28. In the last 12 months, has your doctor examined your feet with your shoes and socks off?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
29. Do you know your blood pressure? If yes, what is it? _____/_____ When was your blood pressure last checked? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
Have you ever gone to your local grocery store or pharmacy to check your blood pressure for free?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
30. In the last 12 months, have you had a urine test for albumin or protein? <i>(This test looks for small substances called proteins in your urine that may be an early indication of kidney problems.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
31. In the last 12 months, have you had a test called a serum creatinine? <i>(This is a blood test that measures how well your kidneys are working.)</i>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
32. In the last 12 months, have you had a serum potassium test?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
33. In the last 12 months, have you had your cholesterol checked? If yes, do you know what your LDL (bad cholesterol) level is? If yes, what is it? _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
34. How do you feel your diabetes is being treated?	Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>
35. Are you unable to work or go to school because of your diabetes?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>	
36. If you are able to work or go to school, how has your diabetes affected your work or school?	Not at all <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>
37. How has your diabetes affected your leisure time or social life?	Not at all <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Often <input type="checkbox"/>	Always <input type="checkbox"/>