Stanford Patient Education Research Center
Stanford University School of Medicine

SAMPLE QUESTIONNAIRE

DIABETES

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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
❑ Black not Hispanic
❑ Hispanic
❑ Asian or Pacific Islander
❑ Filipino
❑ 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

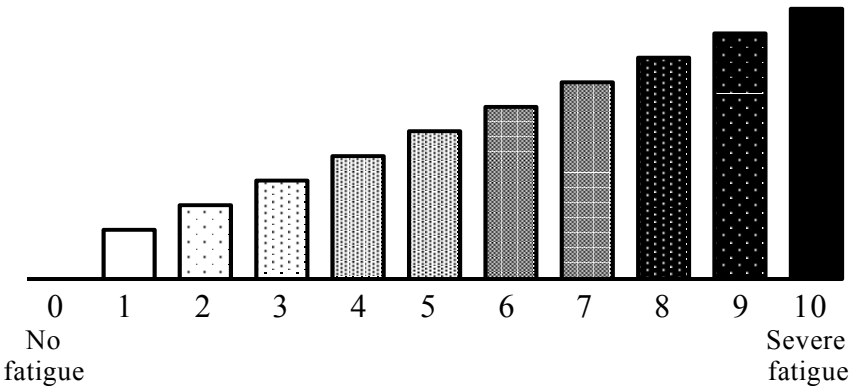
Poor 5

Symptoms

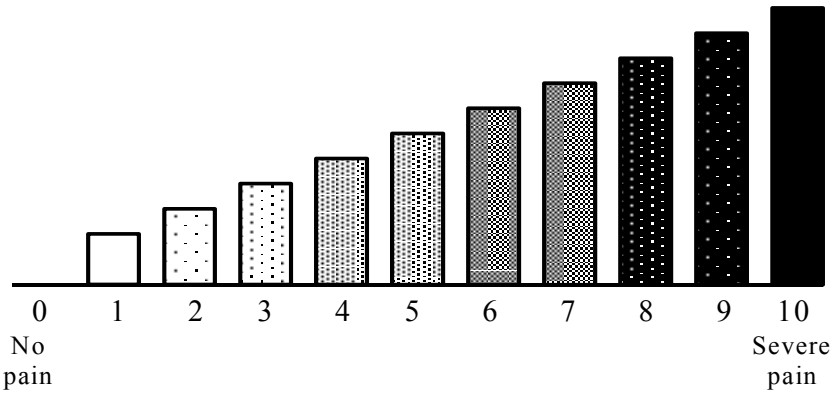
How much time during the **past month**...

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
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

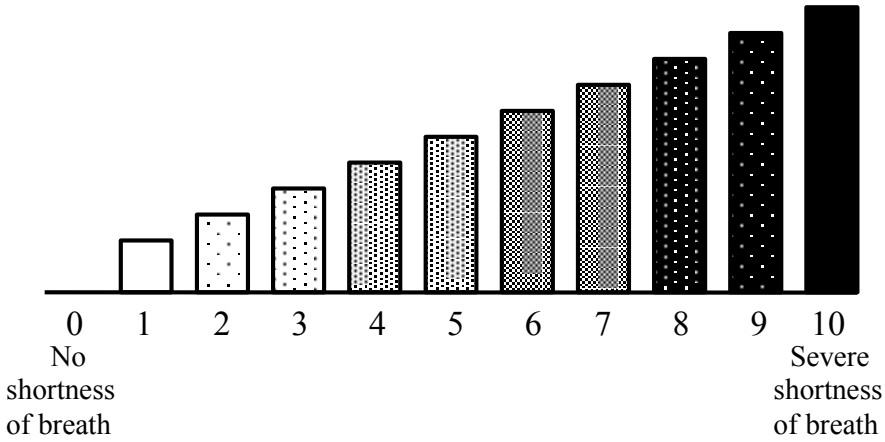
5. We are interested in learning whether or not you are affected by fatigue. Please *circle* the *number* below that describes your **fatigue** in the **past 2 weeks:**



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…

16. Nightmares? ..... ❑ No ❑ Yes ❑ Don't know

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... *(Circle **one**)*

	Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost totally**
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.)*

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

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 confident 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 confident 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 confident 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 confident 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 confident 1 2 3 4 5 6 7 8 9 10 Very confident

6. **How confident** do you feel that you know what

Not at all 1 2 3 4 5 6 7 8 9 10 Very

to do when your blood sugar level goes higher or lower than it should be?

confident 1 2 3 4 5 6 7 8 9 10 confident

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

Not at all confident 1 2 3 4 5 6 7 8 9 10 Very confident

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?

Not at all confident 1 2 3 4 5 6 7 8 9 10 Very confident

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: _____

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):*

	Never	Almost never	Some-times	Fairly often	Very often	Always
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!