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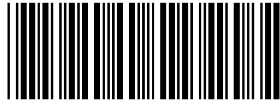

166015

DIABETES LIFECARE PATIENT QUESTIONAIRE

Name: ______________________________ Date: ________________________

Date of Birth: _________________________ Sex: ☐ Female ☐ Male

Address **(Include State, City, Zip Code):** ____

Phone Number(s): __________________ __________________ __________________
(home) (work) (cell)

Doctor's Name: ____________________ Doctor's Phone No. ____________________

√ Race / Ethnicity: ☐ Non-Hispanic White ☐ African American ☐ Hispanic American
☐ Native American ☐ Asian American ☐ Other: _____________

How long have you known that you have diabetes?____________________

Have you had diabetes classes before?
☐ No ☐ Yes (Date and Place): ____________________

Is there a family history of diabetes?
☐ No ☐ Yes (Whom?):

Do you test your blood sugar levels?
☐ No (Why?): ____________________________________
☐ Yes Please √ number of times you test each day:
☐ One ☐ Two ☐ Three ☐ Four ☐ Five or more
When do you test? (√ all that apply):
☐ Before breakfast ☐ Before lunch/ dinner ☐ After meals
☐ At bedtime ☐ Other: _________________________

Have you had *LOW* blood sugars?
☐ No ☐ Yes ☐ I don't know
If yes, please √ how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _________

What time(s) of day do most of your low blood sugars occur? (please √ all that apply)
☐ Morning ☐ Mid Day ☐ Afternoon ☐ Evening ☐ Night
How do you treat low blood sugars? ________________________________

Have you ever lost consciousness or required assistance to reverse low blood sugar?
☐ No ☐ Yes When did it last occur? ____
How often has it occurred? ____

Do you ever have *HIGH* blood sugar levels?
☐ No ☐ Yes ☐ I don't know
If yes, please √ how often: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other: _________

What time(s) of day do most of your high blood sugars occur? (please √ all that apply)
☐ Morning ☐ Mid Day ☐ Afternoon ☐ Evening ☐ At night

How do you treat high blood sugars? ________________________________

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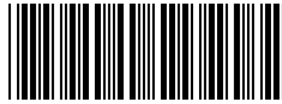

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DIABETES LIFECARE PATIENT QUESTIONAIRE

Do you have any other health problems?

☐ No ☐ Yes (√): ☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol/Triglycerides
☐ Glaucoma ☐ Stroke ☐ Retinopathy (EYE)
☐ Kidney Problems ☐ Asthma ☐ Neuropathy (NERVE)
☐ Teeth or gum ☐ Osteoporosis ☐ Sexual dysfunction
☐ Organ transplant ☐ Thyroid ☐ Polycystic ovaries
☐ Other: ____________________________________

Do you take any medication for these?

☐ No ☐ Yes (please list): ____

____

____

Do you have any of the following problems?

Vision ☐ No ☐ Yes Can you see well with glasses? ☐ No ☐ Yes
Hearing ☐ No ☐ Yes Do you wear a hearing aide? ☐ No ☐ Yes

Please list any medications you take and when: ____________________________________

____

____

Do you take pills for your diabetes?

☐ No ☐ Yes If yes, please list type of pill, time of day and how long you have been taking it:

Pill	Dose	Time taken	Duration of use (For how long?)
______________	________	_____________	________________
______________	________	_____________	________________

Do you take insulin?

☐ No ☐ Yes If yes, do you inject with ☐ a syringe? ☐ an insulin pen?

Please list the type(s) of insulin, # of units, time that you take it and for how long you have been taking it below: (Types of insulin include Novolin N, Humulin N, Humulin 50/50, Humulin L, Humalog, Novolog, Novolin 70/30, 70/30 Novolog, 75/25 Humalog, Lantus, Levemir and Apidra)

Insulin Type	Units	Time taken	Duration of use (For how long?)
______________	________	_____________	________________
______________	________	_____________	________________
______________	________	_____________	________________
______________	________	_____________	________________

Do you use an insulin pump? ☐ No ☐ Yes If yes, please indicate:

☐ Insulin Pump Basal _____units Carbohydrate/Insulin ratio__:___ Correction Factor____

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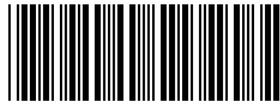

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DIABETES LIFECARE PATIENT QUESTIONAIRE

Do you take the medication Byetta? ☐ No ☐ Yes
If yes, indicate the # of units, time(s) that you take it & how long you have been taking it below:

Units	Time taken	Duration of use (For how long?)
________	____________	_______________

How often do you see your doctor?
☐ Monthly ☐ Every 3 months ☐ Every 6 months ☐ Annually ☐ Every few years ☐ Never
When did you see your *EYE* doctor last? Date:______________________________________
Do you live alone?
☐Yes ☐ No (Whom do you live with?): ____

Do you smoke?
☐ No If quit, when?: ____
☐ Yes (Amount): ____

Do you drink alcohol?
☐ No ☐Yes: ☐ Beer ☐ Wine ☐ Liquor How much? ____________________________
How often? ____
Do you work?
☐ No ☐ Retired ☐ Unemployed
☐ Yes What shift do you work? ☐ Days ☐ Evenings ☐ Nights ☐ Rotating
What are your usual work hours? ____
Having diabetes makes me…. (√ all that apply to you)
☐ Angry ☐Afraid ☐ Confused ☐ Sad ☐ Upset
☐ Feel like I can't do my job
☐ Feel like I can't live the way I want
☐ Feel like I am a sick person
☐ Feel like I should eat better
☐ Other: ____________________________
Is there much *STRESS* in your life?
☐ No ☐ Yes Explain:____
What do you do to handle stress in your life? ______________________________
____
Do you ever get *DEPRESSED?*
☐ No ☐ Yes How often?: ☐ A lot ☐ Some ☐ A little
Do you exercise?
☐ No ☐Yes (√) Favorite types: ☐ Walking ☐ Aerobics/Dance ☐ Elliptical Machine
☐ Swimming ☐ Jogging/Treadmill ☐ Weight Lifting
☐ Cycling/Stationary Bike
☐ Other ____________________
(√) How often: ☐ Daily ☐ 1 to 2 x/week ☐ 3 to 4 x/week ☐ 5 to 6 x/week
☐ 7 x/week or more
(√) Length of workout: ☐ 1-10 minutes ☐ 11-20 minutes ☐ 21-30 minutes
☐ 31-45 minutes ☐ 60 minutes ☐ Other: ___________
Do you have any limitations on exercise?
☐ No ☐ Yes, please describe: ____

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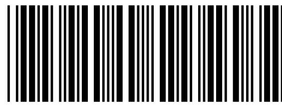

DIABETES LIFECARE PATIENT QUESTIONAIRE

So that we may design a meal plan customized to your needs, please complete the following according to your common practices, and desired changes in lifestyle.

Have you had previous instruction on diet?

☐ **Yes** Where? ______________________________

☐ **No** When? ______________________________

Do you have a meal plan? ☐ No ☐ Yes How many calories? ______________

How much of the time are you able to follow it?

☐ 0%-25% ☐ 25%-50% ☐ 50%-75% ☐ 75%-100%

Do you follow any dietary restrictions or special meals?

☐ No ☐ Yes (√) ☐ Vegetarian ☐ Vegan ☐ Lacto-Ovo ☐ Lacto ☐ Ovo

☐ Low Carbohydrates

☐ Low Fat / Cholesterol

☐ Other: ______________________________

Has your weight changed in the last 6 months?

☐ No ☐ Yes (Describe the change: How many pounds? ________ ☐ Gain ☐ Loss)

Height ________ Age ________ Current/most recent known weight __________

Are you happy with your current weight? ☐ Yes ☐ No

What would you like to weigh? ______________

What has been your highest weight? ____________

If you now weigh less than your highest weight, how did you lose the weight? __________

____

Do you have any *FOOD ALLERGIES?*

☐ No ☐ Yes Food(s): ______________________________

Do you have any *FOOD/BEVERAGE INTOLERANCES* (for example, lactose, spicy foods)***?***

☐ No ☐ Yes Food(s): ______________________________

How is your *APPETITE?* ☐ Good ☐ Fair ☐ Poor

Has there been any recent change in your appetite?

☐ No ☐ Yes (describe): ______________________________

Do you have any eating or digestion problems?

☐ No ☐Yes ☐ chewing ☐ swallowing ☐ stomachache ☐ diarrhea ☐ constipation

☐ other: ______________________________

When eating at home, who prepares the meals?

☐ Self ☐ Spouse/Family member ☐ Meals on wheels ☐ Other

Who does the grocery shopping?

☐ Self ☐ Spouse/Family member ☐ Other ______________________________

Do you follow any cultural / religious dietary restrictions:

☐ No

☐ Yes (Please describe): ______________________________

Do you take vitamins or any other nutrition supplements?

☐ No

☐ Yes (Which ones): ☐ Multivitamins:__________ ☐ Calcium ☐ Vitamin E

☐ Niacin ☐ Chromium ☐ Vitamin B-6

☐ Potassium, salt substitute ☐ Selenium ☐ Iron

☐ Vitamin D ☐ Folic acid ☐ Vitamin B12

☐ Nutritional drink (name, for example Ensure): ______________

☐ Other: ______________

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DIABETES LIFECARE PATIENT QUESTIONAIRE

Do you take any other herbal supplements?

☐ Yes : ☐ Echinacea ☐ Ginseng ☐ Ma-huang ☐ St. John's Wort
☐ No ☐ Garlic ☐ Melatonin ☐ Licorice root/candy ☐ Ginger
☐ Fish Oil ☐ Senna, aloe, buckthorn, cascara bark
☐ Other(s) (please list) ____

Please √ your favorites beverages and the amount you usually drink:

☐ Coffee How many cups per day? ___________
☐ Tea How many cups per day? ___________
What do you add to your coffee or tea? ☐ Milk ☐ Half & Half ☐ Non-dairy creamer
☐ Plain or black ☐ Sugar ☐ Sugar substitute ☐ Honey
☐ Juice ☐ 4 oz. ☐ 8oz. ☐ 12 oz.
☐ Regular soda ☐ 12 oz. Can ☐ 20 oz. ☐ 2 liter bottle
☐ Water # of cups _______ # of bottles _______

Please tell us what you eat in a typical day & how much? Please complete with as much detail as possible. If you skip a meal or snack, please write "NONE."

√	*Time of Day*	*Meals*	*What & how much do you typically eat*
		Breakfast	
		Lunch	
		Supper	
		AM Snack	
		PM Snack	
		Bedtime Snack	
		Other	

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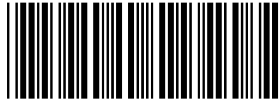
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DIABETES LIFECARE PATIENT QUESTIONAIRE

Please check √ from the following list the foods you eat for meals & snacks, how often & amounts:

Food	Daily √	1-3x/week √	4+ x/week √	Monthly √	Rarely √	**Amount**
White Bread						
Whole Wheat Bread						
Bagel						
Doughnut						
Cold Cereal						
Hot Cereal						
Sausage						
Peanut butter						
Cottage cheese						
Cheese						
Egg						
Sweet roll/pastries						
Potato						
French Fries						
Pasta						
Rice						
Corn or Peas						
Beans						
Poultry						
Beef						
Pork						
Fish						
Shellfish						
Hot Dogs						
Cold Cuts						
Pizza						
Frozen Meals						
Dark Greens						
Salads						
Candy, candy bars						
Desserts – pie, cake						
Ice cream/ other frozen desserts						
Cookies						
Other:						

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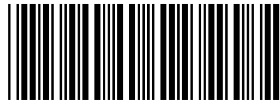

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DIABETES LIFECARE PATIENT QUESTIONAIRE

How often do you eat in restaurants, cafeterias, or away from home?
Breakfast ______x/week Lunch ______x/week Dinner _______x/week

Please check √ which *DAIRY PRODUCTS* you eat or drink?

√	*Type:*	*Milk*	*Yogurt*	*Cheese*
	Regular			
	Reduced fat (2%)			
	Low fat (1%)			
	Part Skim			
	Skim (Fat free)			
	Light			
	None			

How many cups of *MILK* do you drink or use with beverages or cereal daily?
☐ ½ cup ☐ 1 cup ☐ 2 cups ☐ 3 cups ☐ more than 3 cups

If you use the following products, please check the amount you drink on a typical day:

√	*Amount*	*½ cup*	*1 cup*	*2 cups*	*3 cups*	*3+ cups*
	Lactaid:					
	Soy Milk:					
	Rice Milk:					

Please list the *FRUITS* that you like ____

____

____

√	*List Types*	*# of servings per day*
	Canned in heavy syrup	
	Canned in light syrup	
	Packed in juice/No sugar added	
	Fresh:	
	Frozen:	
	None (please explain why):	

Please list the *VEGETABLES* that you like: ____

____

____

√	*List Types*	*# of servings per day*
	Fresh:	
	Canned:	
	Frozen:	
	None (please explain why):	

Please list foods you dislike and will not eat: ______________________________________

____

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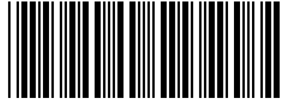
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DIABETES LIFECARE PATIENT QUESTIONAIRE

What eating concerns do you have? ____

What would you like to know more about?
☐ weight loss ☐ eating out ☐ alcohol use ☐ exercise ☐ label reading ☐ sweeteners
☐ Other ____
____

What do you hope to accomplish or gain from this class/appointment? I would like to:
☐ Improve blood sugar ☐ Improve eating habits ☐ Lose weight
☐ Improve exercising ☐ Lower cholesterol/triglycerides ☐ Lower blood pressure
☐ Other: ____

<u>Evaluation of Questionnaire</u>

How long did it take to complete this questionnaire? : _____________Minutes
Do you find this questionnaire to be:

	Agree (√)	Disagree (√)
Understandable		
Legible		
Enough Space to Write		
Too Long		

Did you receive your questionnaire at home?
☐ No ☐ Yes: How long before the program did you receive your questionnaire?
☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 4 weeks ☐ Other: _____________

Did you receive a brochure describing the Diabetes LifeCare program?
☐ No ☐ Yes

<u>Additional Comments</u>