



Stanford Patient Education Research Center

Stanford University School of Medicine

SAMPLE QUESTIONNAIRE

DIABETES

You may use all or parts of the questionnaire at no charge without permission

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self-management@stanford.edu**

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 | ☐ Asian or Pacific Islander |
| ☐ Black not Hispanic | ☐ Filipino |
| ☐ Hispanic | ☐ 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

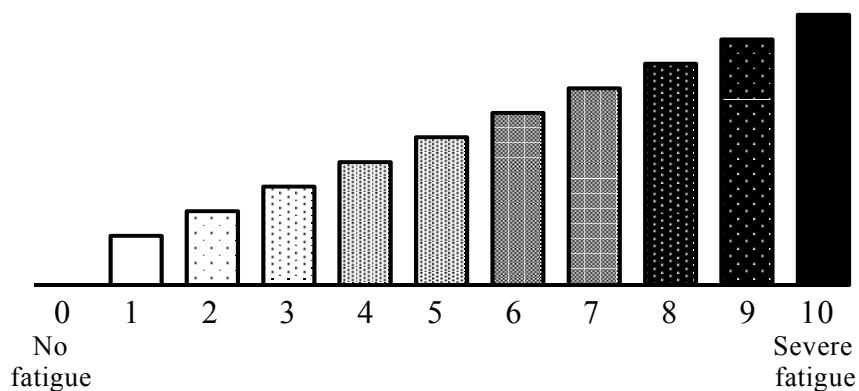
Poor 5

Symptoms

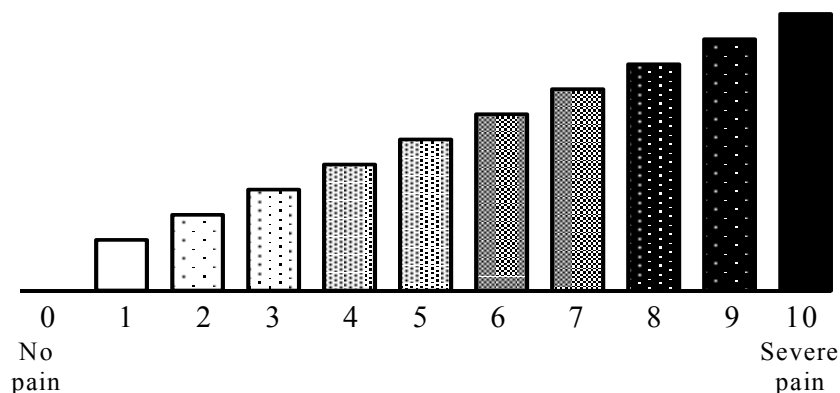
How much time during the **past month...**

	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

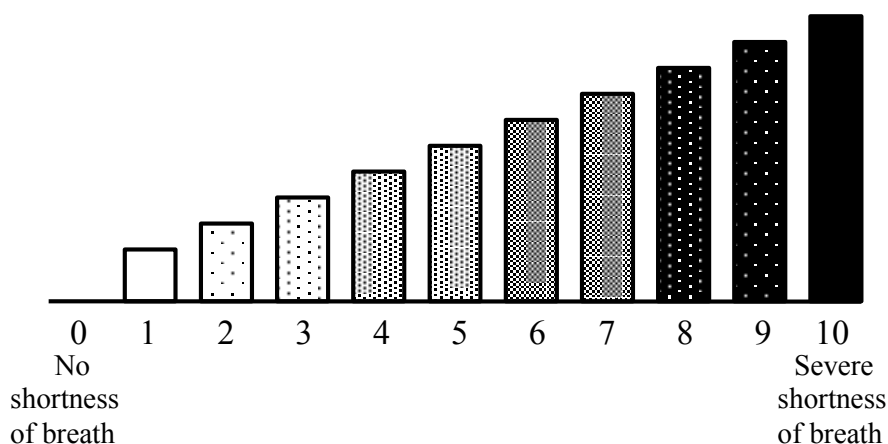
5. We are interested in learning whether or not you are affected by fatigue. Please *circle* the *number* below that describes your **fatigue** in the **past 2 weeks**:



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 <i>Specify</i>	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.

- 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
- 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
- How confident** do you feel that you can choose 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
- 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
- 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
- How confident** do you feel that you know what
 Not at all | | | | | | | | | | 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!