DIABETES QUESTIONNAIRE

Name _____ Date of birth _____
(Please Print) (Date/Month/Year)

Glucose Control

1. On average, how often do you check your blood sugar?

☐ **Once a day** ☐ **5-8 times a day**
☐ **Twice a day** ☐ **More than 8 times a day**
☐ **3-4 times a day**

2. Have you ever been under the care of a diabetes specialist or endocrinologist?

Yes **No**
☐ ☐

If yes, how many times have you visited him/her in the past year?

_____

If no, who helps you look after diabetes?

_____

3. Have you ever tried using 3 or more insulin injections per day or an insulin pump for your diabetes?

Yes **No**
☐ ☐

If yes, how long did you try either of these

If no, please indicate reasons why not

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4. In the last five years have you had any episodes of high blood sugar or diabetic ketoacidosis (DKA) that required a hospital admission or emergency room visit

Yes	**No**
☐	☐

If yes, when did these occur?

<u>Hypoglycemia</u>

1. On average, how often do you experience very low blood sugar (eg. Below 3.0 mmol/1)?

☐ **1-2 times a year**	☐ **2-3 times a month**
☐ **3-5 times a year**	☐ **Once a week**
☐ **6-10 times a year**	☐ **2-5 times a week**
☐ **Once a month**	☐ **Daily**

2. Are you aware when your blood sugar is low?

☐ **Always** ☐ **Frequently** ☐ **Rarely** ☐ **Never**

3. Please indicate which of the following symptoms you experience when you blood sugar is low:

☐ **None**	☐ **Sweating**
☐ **Anxiety/Nervousness**	☐ **Hunger**
☐ **Shakiness/Trembling**	☐ **feeling warm**
☐ **Pounding Heart**	☐ **Nausea**
☐ **Drowsiness**	☐ **Dizziness**
☐ **Headache**	☐ **Confusion**
☐ **Blurred vision**	☐ **Poor concentration**
☐ **Weakness**	☐ **Loss of consciousness**
☐ **Tingling**	☐ **Seizure**

☐ **Other, please specify:**

_____

4. Have you experienced blood sugars that were so low that you did not recognize it yourself and required help from another person (even just to remind you to eat lunch or drink)?

   If yes, how often does this occur? (i.e. Number of episodes per week/per month/per year, etc).

_____

_____

Autonomic Neuropathy

1. Do you regularly have any of the following symptoms?

☐ **Nausea**	☐ **Diarrhea**
☐ **Vomiting**	☐ **Dizziness on standing**
☐ **Bloating**	☐ **Problems with sexual function**

2. If you have any of the above symptom(s), approximately how often so they occur?

☐ **less than once a month**

☐ **1-3 times a month**

☐ **once a week**

☐ **2-3 times a week**

☐ **once daily**

☐ **more than once a day**

Cardiovascular Disease

1. Have you ever had any of the following?

	Yes	**No**
Heart attack	☐	☐
Angina	☐	☐
Balloon angioplasty for blocked arteries	☐	☐
Coronary artery bypass surgery	☐	☐
Other artery bypass surgery (e.g. abdominal aorta, leg artery)	☐	☐

Stroke	☐	☐
Amputation	☐	☐

If yes, please indicate the approximate date(s)

_____

_____

2. Do you have any significant visual loss because of your diabetes? **Yes** **No**

☐ ☐

If yes, please indicate the degree of loss and which eye(s) is/are involved

_____

Diabetic Nephropathy

1. In the last five years, how often do you get your urine checked for protein?

☐ **Never** ☐ **Every year**

☐ **1-2 times** ☐ **more than once a year**

☐ **3-5 times**

2. Have you ever been diagnosed with diabetic kidney disease? **Yes** **No**

☐ ☐

If yes, please indicate the approximate date of the diagnosis.

_____

Diabetic Neuropathy

1. Do you have any loss of sensation or numbness in your hands or feet?

Yes	No
☐	☐

If yes, please indicate the degree of sensory loss.

☐ **Mild** ☐ **Moderate** ☐ **Sever**

2. On average, how often do you check your feet for ulceration or infection?

☐ **Never** ☐ **Once or twice a week**

☐ **Less than once a month** ☐ **Daily**

☐ **Once or twice a month**

3. Have you ever had a sever foot infection? **Yes** **No**

☐ ☐

If yes, please indicate the approximate date(s) this occurred _____

4. Have you ever required ambulance assistance or had to visit a hospital because of low blood sugar?

Yes	No
☐	☐

If yes, for the last one or two episodes, please indicate the approximate dates, what were you doing at the time, and what treatments have you received.

	Date	Circumstance	Treatment
a)	_____	_____	_____
b)	_____	_____	_____

5. Do you own a glucagon injection kit to treat low blood sugar?

Yes	No
☐	☐

If yes, please list approximate date(s). _____

6. Have you ever used a glucagon injection in the past for low blood sugar?

Yes	No
☐	☐

If yes, please list approximate date(s). _____

Diabetic Retinopathy

1. In the last 5 years how often did you get your eyes checked for diabetic eye disease?

☐ Never ☐ Every year

☐ 1-2 times ☐ More than once a year

☐ 3- 5 times

When was your most recent visit? _____

2. Have you ever been diagnosed with diabetic retinopathy (eye disease)? **Yes** ☐ **No** ☐

3. Have you ever received laser treatments for diabetic eye disease? **Yes** ☐ **No** ☐

If yes, please indicate which eye(s) were treated and approximate dates of the treatments.

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