

DIABETES QUESTIONNAIRE

Name: _____ Date of Birth _____
PID# _____

Campus/Local Address: _____

Phone _____ Email _____

1. When were you first diagnosed with diabetes? Year _____ Age _____

2. Please list all medication(s) you take, including dosage :

SKIP TO QUESTION 4 IF YOU DO NOT TAKE INSULIN.

If you use an insulin pump, please fill out the insulin pump section instead.

<u>Time of Injection</u>	<u>Units and Type of Insulin</u>	<u>Units and Type of Insulin</u>
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Where do you give your injection? _____

Do you rotate sites with each injection? ___ Yes ___ No

Any problems with sites (lumping, pitting, etc.)? _____

4. Do you exercise regularly? ___ Yes ___ No . About how many times a week? _____

Types of exercise _____

Usual time of day and length of time: _____

Problems with exercise-related low blood sugar reactions? ___ Yes ___ No

5. Any complications of diabetes? _____

6. Do you smoke? ___ Daily ___ Occasionally ___ Never ___ Stopped
If you stopped smoking how long ago did you stop? _____
How many cigarettes per day do/did you smoke? _____ For how many years? ___
Are you considering stopping? ___ Yes ___ No
7. If you consume alcohol, how much and how often?

If you drink alcohol, what adjustments do you make in your diet or insulin dose?
8. Do you check your blood sugar? ___ Yes ___ No Type of meter _____
How often? _____
9. Do you check your urine for Ketones? ___ Yes ___ No
When? _____
What is your sick day plan? _____
10. Latest results: Hemoglobin A_{1c} Month/year _____ Result _____
Urine Microalbumin Month/year _____ Result _____
Cholesterol Month/year _____ Result _____
Dilated eye exam Month/year _____ Result _____
11. Have you had low blood sugar reactions lately? ___ Yes ___ No

What times of the day? _____

Ever passed out or had a seizure due to low blood sugar? _____
12. Have you had symptoms of high blood sugar lately? ___ Yes ___ No

Which? _____
(fatigue, hunger, thirst, frequent desire to urinate, trouble focusing vision)
13. Have you had problems with infections? ___ Yes ___ No

Which? _____
(acne, burning on urination, frequent colds, itching in groin or feet, boils)
14. Have you been hospitalized for your diabetes? ___ Yes ___ No

Date and where Hospitalized: _____

What was the problem? _____

- 15. Why do you eat? to avoid low blood sugar reactions for energy
 to please others frustration stress to stay healthy
 depression for comfort boredom

Style of eating: All day Only when hungry Fairly regular meal times

- 16. What is the most challenging aspect of nutrition for you? _____

- 17. Have you ever attended sessions with a registered dietitian? Yes No.
 When _____

- 18. In what ways have you have adapted to having diabetes?

- 19. Regarding diabetes, have you recently felt angry, sad, scared, stressed, (circle those which apply)

- 20. Would you like a UNC student or post doc who has diabetes to contact you?
 Yes No
 If yes, how may they contact you? _____

- 21. What goals do you have for living well with diabetes? _____

- 22. Who have you seen recently for diabetes care? (Doctor's name, address, phone)

Thank you for your help completing and returning this questionnaire to the address below.

Please ask your current diabetes doctor to send your latest diabetes care records to:

Margaret Vimmerstedt MD
 University of North Carolina
 Campus Health Service, CB# 7470
 Chapel Hill, NC 27599-7470
 Office: 919 966-6562 Apts: 919 966-2281

If you currently have an insulin pump, please complete the following:

1. Brand and model of insulin pump:
2. When did you begin using a pump?
3. What do you find most helpful with the pump?
4. Type of Insulin:
5. Basal insulin rates:

Start time							
Units/hr							

6. Bolus for carbohydrate: ____ unit: ____ grams of carb
7. Bolus scale for high blood sugar:
 Insulin sensitivity 1unit lowers glucose _____mg/dl Target glucose _____
8. Are you consistent with.....
 monitoring 4 or more times a day? Almost always____ Usually____ Rarely _____
 checking ketones if over 250? Almost always____ Usually____ Rarely _____
9. What adjustments do you make for extra exercise?
10. What is your plan for sick days?
11. Do you have long acting insulin as a back up?
12. Do you see your Endocrinologist or Diabetes care physician on a regular basis?
 If not, what are barriers to getting care? (Transportation, Insurance, Time)
13. Have you needed to contact your doctor for any urgent diabetes care since you have been using the pump?