

ID# _ _ _ _ _

Name _____

Today's Date _____

DIABETES HISTORY

Michigan Diabetes
Research and Training Center
DH2.0

© 1998 The University of Michigan

First, we would like to ask you about the health care you have received recently.

Please answer every question by filling in the blank(s), circling the correct answer, or checking the correct box.

Section I – Resource Use

Q1. During the past 4 weeks, how many total visits to health care providers (doctors, nurse practitioners, etc.) did you make? (fill in the blanks)

___ visits in the past 4 weeks

Q2. During the past 12 months, how many total visits to health care providers did you make? (fill in the blanks)

___ visits in the past 12 months

Q3. When was your last visit with the following health care providers?

a. My last visit with an **ophthalmologist** was: (check one box)
(An ophthalmologist is a physician who specializes in the care and surgery of eye diseases, not an optometrist)

₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a visit with an ophthalmologist

b. My last visit with an **optometrist** was: (check one box)
(An optometrist is a person professionally trained to test the eyes and to detect and treat eye problems and some diseases, not an ophthalmologist)

₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a visit with an optometrist

c. My last visit with a **podiatrist** was: (check one box)
(A podiatrist is a physician who treats and takes care of people's feet)

- ₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a visit with a podiatrist

d. My last visit with a **dietitian** was: (check one box)

- ₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a visit with a dietitian

e. My last visit with a **diabetes educator** was: (check one box)

- ₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a visit with a diabetes educator

Q4. When was the last time that you had an eye exam during which the doctor put drops in your eyes that made your pupils large? (You may have been unable to see enough to drive or had to wear dark glasses afterward.) (check one box)

- ₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had this type of eye exam

Q5. When was the last time that you had the following blood tests?

- a. My last **Hemoglobin A1c test** was: (check one box)
(This is also known as glycohemoglobin or glycosylated hemoglobin, a test that measures your average blood sugar level over the past couple of months)

₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a Hemoglobin A1c test

- b. My last **Cholesterol blood test** was: (check one box)

₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a cholesterol blood test

- c. My last **Urine analysis** was: (check one box)
(Gave a urine sample to be tested by the health care provider, clinic, or laboratory)

₁ Within the last 12 months ₂ 1-2 years ago ₃ 2-3 years ago ₄ More than 3 years ago ₅ Never had a urine analysis

Q6. Do you check your own blood sugar? (check one box)

₁ No ₂ Yes → Q6a. During the past 7 days, how many times have you checked your own blood sugar?
— — times

Q7. How often do you check your feet for signs of problems? (check one box)

- ₁ Not at all
₂ Monthly
₃ Weekly
₄ Daily

Q8. During the past 12 months, were you a patient in a hospital overnight? (check one box)

₁ No

₂ Yes



Q8a.

How many times in the past 12 months did you stay in a hospital overnight?

__ __ times



Q8b.

How many nights altogether during the past 12 months did you stay in a hospital?

__ __ __ nights

Q9. Have you ever been hospitalized for diabetic ketoacidosis (DKA)? (check one box)

₁ No

₂ Yes

₃ Don't Know

Section II – Medication Use

Q1. Do you now use insulin? (check one box)

₁ No

₂ Yes →



Q1a. How many times during the day do you usually take your insulin? (check one box)

₁ Once a day (Taken in the **Morning**)

₂ Once a day (Taken in the **Evening**)

₃ Twice a day

₄ Three times a day

₅ Four or more times a day

₆ I use an infusion pump



Q1b. How long have you taken insulin?

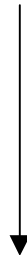
__ __ years



Q1c. Have you taken insulin for as long as you have had diabetes? (check one box)

₁ No

₂ Yes



Q2. Are you currently taking any of the following diabetes pills?
(circle one answer on each line)

	No	Yes
1. Glucotrol (glipizide)	1	2
2. Micronase, Glynase, or Diabeta (glyburide)	1	2
3. Amaryl (glimepiride)	1	2
4. Tolinase (tolazamide)	1	2
5. Diabinese (chlorpropamide)	1	2
6. Glucophage (metformin)	1	2
7. Precose (acarbose)	1	2
8. Rezulin (troglitazone)	1	2
9. Prandin (repaglinide)	1	2
10. Other (please specify below): _____	1	2

Q3. In the past year, has **your health care provider** made changes in your insulin or pill dose on the basis of your home blood tests? (check one box)

- ₁ No
- ₂ Yes
- ₃ Not using medications
- ₄ Don't test

Q4. In the past year, have **you** made changes in your insulin or pill dose on the basis of your home blood tests? (check one box)

- ₁ No
- ₂ Yes
- ₃ Not using medications
- ₄ Don't test

Q5. Do you change the timing/content of a meal on the basis of your home blood tests?
(check one box)

₁ No

₂ Yes

₃ Don't test

Q6. Have you been taught to change your insulin dose on the basis of your blood sugar tests? (check one box)

₁ No

₂ Yes

₃ Not using insulin

₄ Don't test

Q7. Are you currently taking medications for high cholesterol? (Check one box)

₁ No

₂ Yes

₃ Don't know

Section III - Satisfaction

Q1. These questions ask about the diabetes care you have received recently.
(circle one answer on each line)

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
A. I'm very satisfied with the diabetes care I receive.	1	2	3	4	5
B. Most people receive diabetes care that could be better.	1	2	3	4	5
C. The diabetes care I have received in the last few years is just about perfect.	1	2	3	4	5
D. There are things about the diabetes care I receive that could be better.	1	2	3	4	5

Q2. Who currently provides your main diabetes health care? (check only one box)

- ₁ Generalist (general practitioner, family practitioner, internist, or nurse, nurse practitioner, physician assistant working with a generalist)
- ₂ Specialist (diabetologist, endocrinologist, or nurse, nurse practitioner, physician assistant working with a diabetologist or endocrinologist)
- ₃ Other (please specify): _____
- ₄ No one, I do not have a regular health care provider who provides my diabetes care

Section IV - Comorbidities

Q1. Have you ever been told by a health care provider that you have any of the following problems with your eyes? (circle one answer on each line)

	No	Yes, on one eye	Yes, on both eyes
A. Cataracts	1	2	3
B. Glaucoma	1	2	3
C. Detached retina	1	2	3
D. Blurred vision (not correctable with eye glasses)	1	2	3
E. Retinopathy (diabetic changes in the back of the eye)	1	2	3
F. Blindness	1	2	3
G. Macular degeneration (an aging change in the back of the eye)	1	2	3
H. Macular Edema	1	2	3

Q2. Have you ever had any of the following operations on your eyes?
(circle one answer on each line)

	No	Yes, on one eye	Yes, on both eyes
A. Cataract Surgery	1	2	3
B. Laser Treatment	1	2	3
C. Other (please specify below): _____	1	2	3

Q3. Have you ever been told by a health care provider that you have any of the following problems related to your heart or circulation? (circle one answer on each line)

	No	Yes
A. Heart attack	1	2
B. Heart failure	1	2
C. High cholesterol	1	2
D. Angina	1	2

Q4. Have you ever been told by a health care provider that you have high blood pressure? (check one box)

₁ No

₂ Yes



Q4a.

How many years ago were you told that you have high blood pressure?

— — years ago



Q4b.

Do you now take medication for your high blood pressure? (Check one box)

₁ No

₂ Yes



Q5. Have you ever had any of the following operations or procedures related to your heart? (circle one answer on each line)

	No	Yes
A. Coronary artery bypass surgery (open heart surgery)	1	2
B. Coronary angioplasty (“balloon” heart procedure)	1	2
C. Heart catheterization (angiogram)	1	2

Q6. Have you ever been told by a health care provider that you have any of the following bladder, kidney, or urinary problems? (circle one answer on each line)

	No	Yes
A. Kidney or bladder infections	1	2
B. Kidney failure	1	2
C. Protein in your urine	1	2
D. Enlarged prostate (Men only)	1	2
E. Vaginitis (Women only)	1	2

Q7. Have you ever been told by a health care provider that you have any of the following problems with your feet or legs? (circle one answer on each line)

	No	Yes
A. Peripheral vascular disease (poor circulation in the legs)	1	2
B. Intermittent claudication (cramping in the calves after exercise)	1	2
C. Peripheral neuropathy (nerve problems causing numbness, tingling, or burning)	1	2
D. Gangrene	1	2
E. Foot ulcers	1	2
F. Athlete's foot or fungus infection of the feet	1	2

Q8. Have you ever had an amputation of a toe, foot, part of a leg, or all of a leg **for a poorly healing sore or poor circulation**? (An amputation that is **not** due to an injury or accident [car crash, power tool injury, war injury, etc.]?)

	No	Yes, <u>right</u> side only	Yes, <u>left</u> side only	Yes, <u>both</u> sides
A. Toes	1	2	3	4
B. Part of a foot (or feet)	1	2	3	4
C. Leg, below the knee	1	2	3	4
D. Leg, above the knee	1	2	3	4

Q9. Have you ever been told by a health care provider that you have had any of the following problems?

	No	Yes
A. Stroke	1	2
B. Transient ischemic attacks (TIA or “mini-strokes”)	1	2
C. Epilepsy or seizure disorder	1	2
D. Parkinson’s Disease	1	2

Q10. During the **past 4 weeks**, how many days have you lost from school, work, or household activities due to illness or injury?

___ ___ days

Section V – Background Information

Q1. How tall are you?

___ feet ___ inches

Q2. How much do you currently weigh?

___ pounds

Q3. Do you wear or carry some kind of diabetes identification (wallet card, bracelet, etc.)?

₁ No

₂ Yes

Q4. In the last three months, have you been drinking alcoholic drinks at all (e.g. beer, wine, wine cooler, sherry, gin, vodka or other hard liquor)?

₁ No

₂ Yes

Q4a. How many days in a week do you typically have something to drink? (circle one answer)

None 1 2 3 4 5 6 7

Q4b. On days that you drink, how many drinks do you typically have? (circle one answer)

1 2 3 4 5 6 7 8 9 10 11 12 13 14 or more

Q4c. What is the **most** you had to drink in any one day during the past 3 months? (circle one answer)

None 1 2 3 4 5 6 7 8 9 10 or more

Q5. Have you ever smoked cigarettes? (check one box)

₁ No

₂ Yes

Q6. Do you now smoke cigarettes? (check one box)

₁ No

₂ Yes



Q6a. How many packs per day do you smoke?

_____ packs per day



DM History Appendices

Below are additional questions that can be added to the Diabetes History Instrument.

Section VI – Reasons patient came to the clinic

Q1. How did you first hear about this clinic? (check one box only)

- ₁ Letter from the _____
- ₂ My health care provider
- ₃ Newspaper
- ₄ My diabetes educator
- ₅ A public health nurse
- ₆ Support group/friends/other patients
- ₇ Other, please list: _____

Q2. What was the most important reason you came to the clinic? (check one box only)

- ₁ To see if diabetes was affecting my health
- ₂ My health care provider told me to come
- ₃ My diabetes educator told me to come
- ₄ It was a free clinic
- ₅ Other, please list: _____

Q3. What are the three most difficult problems you face in caring for your diabetes? (Try to be as specific as possible - if you can't think of three problems, list as many as you can think of.)

1. _____

2. _____

3. _____

Section VII – For Women Only

If you are a woman please complete this section (Section VII).

Q1. Have you ever been pregnant? (check one box)

₁ No

₂ Yes



Q1a.

How many times have you been pregnant?

__ __ times

If No, skip
questions
Q1a – Q1d



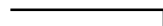
Q1b.

Were you ever told by a health care provider that you had gestational diabetes or high blood sugar during a pregnancy? (check one box)

₁ No

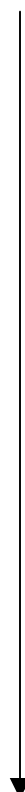
₂ Yes

₃ Not Sure



If Yes:

		No	Yes	Not Sure
Q1b1.	Were you told to have your blood sugar checked before becoming pregnant again?	1	2	3
Q1b2.	Were you told to have your blood sugar checked after delivery?	1	2	3



Q1c. Did you have diabetes before you became pregnant? (check one box)

₁ No

₂ Yes

₃ Not Sure

If Yes:

	No	Yes	Not Sure
Q1c1. Were you ever told to seek medical care before becoming pregnant?	1	2	3

Q1d. Did any of your babies weigh over 9 lbs at birth? (check one box)

₁ No

₂ Yes

Section VIII - Detailed Diet / Nutrition Counseling

Q1. Did you ever see a dietitian to learn about a diabetic meal plan or diet? (check one box)

₁ No

₂ Yes



Q1a.

About how many times have you seen a dietitian?

If No, skip
questions
Q1a – Q1c1



₁ 1-2 times

₂ 3-5 times

₃ More than 5 times



Q1b.

When was the last time you saw a dietitian to learn about or review your diabetes meal plan or diet? (please enter the year)

— — — —



Q1c.

Was there a charge for seeing the dietitian the last time? (check one box)

₁ No, there was not a charge

₂ Yes, there was a charge

₃ Not sure if there was not a charge



Q1c1. If Yes, who paid for the charge for seeing the dietitian? (check one box)

₁ I did

₂ Insurance company

₃ Wasn't paid

₄ Not sure

Q2. If you have never seen a dietitian, why not? (check one box)

- ₁ Costs too much
- ₂ Not sent by my health care provider
- ₃ Did not feel it was important
- ₄ Didn't know I was supposed to
- ₅ My health care provider tells me about my diet
- ₆ Other, please list: _____

Section IX – Other Information

A. Scoring for the Alcohol Questions

Quantity x frequency =

If quantity x frequency > 7 drinks a week for women and >14 drinks for men, or if maximum >3 for women and >4 for men, then patient exceeds criteria for low-risk drinking

B. Cost Effectiveness Analyses

Essential:

Section I: Q1, Q3a-b, Q4, Q5a-c, Q6, Q8, and Q9

Section II: Q1a, Q2, and Q7

Section IV: Q4a-b, Q9, and Q10

Section V: Q5 and Q6

Useful in most instances:

Section I: Q3c-e

Section II: Q1

Section IV: Q1a-h, Q2, Q3, Q5, Q6, Q7, and Q8

Also, resource use section in the appendix

Best for complete analysis:

Any comorbidity that you think could vary between treatment groups given the duration of your study (See Section IV and comorbidities section in the appendix)

Kaplan “Quality of well-being scale”

C. Diabetes Classification

To classify someone as having type 1 vs type 2 diabetes, you need:

Section I (Q9), Section II (Q1c), and age of diagnosis (calculated from date of birth and date of dm diagnosis in DCP)

Add to Section I – Resource Use

Q10. During the past 4 weeks, how many times have you:

- a. Called a health care provider on the phone? __ __ times
- b. Had a regularly scheduled out-patient visit(s)? __ __ times
- c. Had urgent care visit(s)? __ __ times
- d. Had emergency room visit(s)? __ __ times

Add to Section II – Medication Use

Q8. Do you currently take vitamin supplements?

₁ No

₂ Yes



Q8a.

If Yes, Please list all supplements:



Q9. Do you currently take herbal medications?

₁ No

₂ Yes



Q9a.

If Yes, Please list all herbal medications:



Add to Section III – Satisfaction

Q3. Thinking back over the past 12 months, how would you rate the diabetes care you have received with regard to:

	Poor	Fair	Good	Very Good	Excellent
A. Keeping you informed about what the next step in your care would be.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
B. Different health care providers being up-to-date on your current treatments and recent test results.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
C. Communication between the different health care providers caring for you.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅
D. Knowing who to ask when you had questions about your health.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅

Add to Section IV – Comorbidities

Here are questions on important comorbid conditions from the Diabetes PORT. Researchers may wish to drop modules, but we would recommend against dropping individual items from a module if you want to construct a severity or casemix scale.

Q11. Have you ever been told by a health care provider that you have any of the following problems with your breathing? (circle one answer on each line)

	No	Yes
A. Emphysema	1	2
B. Chronic bronchitis	1	2
C. Asthma	1	2

Q12. Have you ever been told by a health care provider that you may have any of the following problems? (circle one answer on each line)

	No	Yes
A. Peptic or stomach ulcer	1	2
B. Liver disease	1	2
C. Ulcerative colitis (or Crohn’s Disease)	1	2
D. Irritable or functional bowel disease	1	2
E. Gallstones or gallbladder disease	1	2

Q13. Have you ever been told by a health care provider that you have:
(circle one answer on each line)

	No	Yes
A. Osteoarthritis or degenerative joint disease	1	2
B. Rheumatoid arthritis	1	2
C. Slipped or herniated disc in your back	1	2
D. Osteoporosis (or thinning bones)	1	2

Diabetes History (Summary)

Core Questions

Section I – Resource Use (Q1 – Q9)

Section II – Medication Use (Q1 – Q7)

Section III – Satisfaction (Q1 –Q2)

Section IV – Comorbidities (Q1 – Q10)

Section V – Background Information (Q1 – Q6)

Appendices

Potential new sections:

Section VI – Reasons patient came to clinic (Q1 – Q3)

Section VII – For women only (Q1)

Section VIII – Detailed diet / nutritional counseling (Q1 – Q2)

Section IX – Other Information (Scoring for alcohol questions, cost effectiveness questions, and diabetes classification)

Questions to add to the end of sections:

Add to Section I – Resource Use (Q10)

Add to Section II – Medication Use (Q8-Q9)

Add to Section III – Satisfaction (Q3)

Add to Section IV – Comorbidities (Q11 – Q13)