Hartford Hospital
A Hartford HealthCare Partner

166015

DIABETES LIFECARE PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Sex: □ Female □ Male

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

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

E-Mail address (optional) _____

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

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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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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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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: _____

Evaluation of Questionnaire

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

Additional Comments