

This instrument was created and developed by the TRIAD Study, 2000.

Health Care Questionnaire



<HP> is participating with the Centers for Disease Control and Prevention in a national study to improve the quality of health care being delivered to persons with diabetes. As part of that project, survey information is being collected from members of <HP> to learn more about their health and the type of care they receive. We realize that there are quite a few questions, but the information is very important. It will be used to help design new methods to improve diabetes health care delivery.

There are no right or wrong answers. We are interested in **your experiences**, so please answer each question honestly. **All answers you give will be kept private.** This is so because the study has been given a Certificate of Confidentiality. This means anything you tell us will not have to be given out to anyone, even if a court orders us to do so, unless you say it is okay. When you complete the survey, please return it in the enclosed self-addressed stamped envelope. Thank you in advance for your help.

Directions

Read each question carefully and place a check in the box that most closely reflects your experience. Depending on your answers, you might be asked to skip some of the questions on this survey.

1. Are you currently a member of <HP>?

Yes

No

(If no, this survey is complete. Please return in the envelope provided.)

2. Is <HP> the primary source for your health care?

Yes

No

(If no, this survey is complete. Please return in the envelope provided.)

3. Has a doctor or other health professional *ever* told you that you had diabetes, also known as sugar diabetes or high blood sugar?

Yes

No

(If no, this survey is complete. Please return in the envelope provided.)

4. IF YOU ARE FEMALE: If you have ever been pregnant, did you have diabetes only while you were pregnant?

Yes

(If yes, this survey is complete. Please return in the envelope provided.)

Unsure

(If unsure, this survey is complete. Please return in the envelope provided.)

No

5. IF YOU ARE FEMALE: Are you currently pregnant?

Yes

(If yes, this survey is complete. Please return in the envelope provided.)

Unsure

(If unsure, this survey is complete. Please return in the envelope provided.)

No

6. Do you currently have diabetes?

Yes

No

(If no, this survey is complete. Please return in the envelope provided.)

7. About how old were you when you were first told you had diabetes?

8. What is your birth date?

_____/_____/_____
(mo/day/yr)

9. What is your gender?

Male Female

10. How tall are you without your shoes?

_____ feet _____ inches

*National Center for Health Statistics. [Health, United States, 2000](#). Hyattsville, Maryland: Public Health Service. 2000.

11. How much do you weigh without clothes?

_____ pounds

*National Center for Health Statistics. [Health, United States, 2000](#). Hyattsville, Maryland: Public Health Service. 2000.

12. How do you **currently** manage or control your diabetes? (*Check all that apply*)

Diet &/or exercise only

Oral medications

Insulin injection

Insulin pump

Other (please list) _____

13₁₅. Do you test your blood sugar levels at home?

Yes

No

(If no, skip to question 15.)

14₁₈. During the *past year*, how often did your doctor or some other health care professional review your home blood or urine sugar test results?

Every visit

Most of the visits

At least one of the visits

None of the visits

Not sure

15₁₉. When was the last time you had an eye exam in which your pupils were dilated (drops in your eyes that make you temporarily sensitive to bright light)?

- During the past 12 months
- More than a year but less than 2 years
- More than 2 years
- Never
- Not sure

16₂₀. During the *past year*, how often did your doctor or some other health care professional examine your feet with your socks off?

- Every visit
- Most of the visits
- At least one of the visits
- None of the visits
- Not sure

17₂₂. Has your doctor or some other health care professional told you to take aspirin regularly to lower your risk of developing heart disease or stroke?

- Yes
- No
- Unsure

18₂₃. Did you get a flu shot during the *past 12 months*?

- Yes
- No

19₂₄. In the *past year*, have you smoked cigarettes every day, some days, or not at all?

- Every day
- Some days
- Not at all

(If not at all, skip to question 21.)

20₂₅. Were you advised by a doctor or other health care provider to quit?

- Yes
- No

21₃₄. During the *past 4 weeks* have you experienced the following:

A. Dry mouth?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

B. Having to get up at night to urinate?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

C. Frequent urination?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

D. Excessive thirst?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

E. Blurred or double vision?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

F. Decreased ability to feel hot or cold with your hands or feet?

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

22³⁷. In general, would you say your health is:

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

The next set of questions ask for your views on your health. First, please consider activities that you might do during a *typical day*. Does your health now limit you in these activities? If so, how much?

23³⁸. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.

- 1 Yes, limited a lot
- 2 Yes, limited a little
- 3 No, not limited at all

24³⁹. Climbing **several** flights of stairs.

- 1 Yes, limited a lot
- 2 Yes, limited a little
- 3 No, not limited at all

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

25⁴⁰. Accomplished less than you would like as a result of your physical health?

- 1 Yes
- 2 No

26⁴¹. Were limited in the **kind** of work or other regular daily activities?

- 1 Yes
- 2 No

During the *past 4 weeks*, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems, such as feeling depressed or anxious?

27⁴². Accomplished **less** than you would like?

- 1 Yes
- 2 No

28⁴³. Didn't do work or other activities as **carefully** as usual?

- 1 Yes
- 2 No

29⁴⁴. During the past four weeks, how much did pain interfere with your normal work, including both work outside the home and housework?

Would you say it interfered:

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

The next questions are about how you feel and how things have been with you *during the past 4 weeks*. For each question, please give the one answer that comes closest to the way you have been feeling.

30⁴⁵. How much of the time during the past 4 weeks:

A. Have you felt calm and peaceful?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

B. Did you have a lot of energy?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

C. Have you felt downhearted and blue?

- 1 All of the time
- 2 Most of the time
- 3 A good bit of the time
- 4 Some of the time
- 5 A little of the time
- 6 None of the time

D. Has your physical health or emotional problems interfered with your social activities like visiting with friends and relatives ***during the past 4 weeks***?

- 1 All of the time
- 2 Most of the time
- 3 Some of the time
- 4 A little of the time
- 5 None of the time

31₄₈. A personal doctor or nurse is the health care provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have one person you think of as your personal doctor or nurse?

- Yes → **If yes**, what is his/her name?

- No

32₅₂. Would you say the person that you go to for your **diabetes** care is:

- A family practice physician
 An internal medicine doctor
 An endocrinologist or diabetes specialist
 Another type of physician
 A nurse or physician's assistant
 Unsure

33₈₂. Some people have more than one type of insurance. Do you have any of the following types of health insurance?

(Check all that apply)

- No, I do not have any other type of health insurance
- Other private health insurance
- Medicare
- Supplemental Medicare
- Medicaid
- Veterans Administration (VA)
- Other (*please write in*)

- Unsure

34₈₃. Does <HP> pay for most of your health care needs?

- Yes
 No

35₉₄. Which income category below best describes your total annual household income before taxes?

- Less than \$15,000
 \$15,000 to under \$40,000
 \$40,000 to under \$75,000
 \$75,000 and above

36₉₅. What is the highest grade of school that you completed?

- 8th grade or less
 Some high school, but did not graduate
 High school graduate or GED
 Some college or 2-year college degree
 4-year college graduate
 More than 4-year college degree

37₉₆. Are you of Hispanic or Latino origin?

- Yes
 No

→ **If yes**, is that:

- Cuban, Puerto Rican, other Caribbean (specify): _____
- Mexican American, or Chicano/a (specify): _____
- Other Central or South American (specify): _____
- Other Hispanic/Latino (specify): _____

38₉₇. What is your race?

(Please select all that apply)

- American Indian or Alaska Native
- Asian – Is that: Chinese
 Filipino
 Japanese
 Korean
- Asian (or East) Indian
- Native Hawaiian
- Pacific Islander
- Black or African American
- White
- Other (specify): _____

Thank you for completing this survey!