

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

- ₁ Diet &/or exercise only
- ₂ Oral medications
- ₃ Insulin injection
- ₄ Insulin pump
- ₅ Other (*please list*) _____

13. **If you use insulin injections**, how many times per day do you usually take your insulin?

- ₁ Once a day
- ₂ Twice a day
- ₃ Three times a day
- ₄ More than three times per day

14. For the next set of items, please indicate if your current doctor or other health care provider (such as a diabetes educator or nurse) in your doctor's office explained to you, showed you or gave you information about the following:

	<u>Yes</u>	<u>No</u>	<u>Unsure</u>
		1	2
₃			
A. How to care for your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. What to do for symptoms of low blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. How to exercise appropriately?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. What is a good number for your blood sugar?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. How to adjust your diabetes medications in response to blood sugar values on sick days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- ₁ Yes
- ₂ No (*If no, skip to question 19.*)

16. How many **days a week** do you test your blood sugar?

- ₁ ₂ ₃ ₄ ₅ ₆ ₇

17. When you test your blood sugar, how many times **per day** do you usually test?

- ₁ ₂ ₃ ₄ or more

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

- 1 Every visit
- 2 Most of the visits
- 3 At least one of the visits
- 4 None of the visits
- 5 Not sure

19. 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)?

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

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

- 1 Every visit
- 2 Most of the visits
- 3 At least one of the visits
- 4 None of the visits
- 5 Not sure

21. When was the last time a doctor or other health professional tested the feeling in your feet or legs by touching them with a monofilament (which looks like a short piece of fishing line)?

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

22. 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?

- 1 Yes
- 2 No
- 3 Unsure

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

- 1 Yes
- 2 No (*If no, skip to question 24.*)

23a. → **If Yes**, did you get your flu shot through your health plan?

- ₁ Yes
- ₂ No
- ₃ Unsure

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

- ₁ Every day
- ₂ Some days
- ₃ Not at all (***If not at all, skip to question 28.***)

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

- ₁ Yes
- ₂ No (***If no, skip to question 28.***)

26. Were you referred to a smoking cessation program by a doctor or other health care provider?

- ₁ Yes
- ₂ No

27. Were medications recommended or prescribed by a doctor or other health care provider to help you quit smoking?

- ₁ Yes
- ₂ No

28. During the past 12 months, ***have you received any of the following types of diabetes-related information*** from your doctor's office or health care plan:

	<u>Yes</u>	<u>No</u>	<u>Unsure</u>	
	1	2	3	
A. Diabetes materials (e.g. pamphlets or newsletters, audiotapes or videotapes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
B. Reminders about upcoming appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
C. Reminders that diabetes-related services or tests are due	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
D. A copy of diabetes-related laboratory results after or between visits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
E. Information about diabetes education (such as support groups or one-on-one counseling, advice services, or Internet sites)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. During the past 12 months, **have you used** any of the following diabetes-related services or attended any of the following diabetes-related programs:

	<u>Yes</u> 1	<u>No</u> 2	<u>Unsure</u> 3
A. A diabetes support group	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. One-on-one or group diabetes education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. A diabetes-related Internet site	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. A personal diabetes health record (also sometimes called a "passport") to remind you and your health care provider about your diabetes-related care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. Have you ever been told by a doctor or someone in your doctor's office that you have high cholesterol or triglycerides or elevated lipids (fatty substance in the blood)?

- ₁ Yes
₂ No

31. Have you ever been told by a doctor or someone in your doctor's office that you have had a heart attack, a "coronary" or a myocardial infarction?

- ₁ Yes
₂ No

32. Have you ever been told by a doctor or someone in your doctor's office that you have had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or a transient ischemic attack or "mini-stroke"?

- ₁ Yes
₂ No

33. **Have you ever had any of the following procedures:**

	<u>Yes</u> 1	<u>No</u> 2	<u>Unsure</u> 3
A. Surgery to bypass or unclog arteries to your heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Angioplasty or a balloon to unclog arteries to your heart or leg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. A toe, foot, or leg amputation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

➔ If Yes, what was amputated?

- ₁ One or more toes, but neither foot
₂ One foot (or leg), but not both feet
₃ Both feet (or legs)

34. During the PAST 4 WEEKS have you experienced the following:

	All of the Time 1	Most of the Time 2	Some of the Time 3	Little of the Time 4	None of the Time 5
A. Dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Having to get up at night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Frequent urination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Excessive thirst?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Blurred or double vision?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Decreased ability to feel hot or cold with your hands or feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(SKIP G-J AND 35 IF YOU HAVE HAD BOTH FEET AMPUTATED.)

G. Numbness or loss of feeling in your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Tingling or burning sensation in your feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Sores or wounds on your feet that did not heal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Dry or cracked feet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

35. Do you or someone in your home check your feet for sores every day?

- ₁ Yes
₂ No

36. Has your doctor or other health care professional talked with you about whether you experienced any decrease in sexual interest or performance?

- ₁ Yes
₂ No

Question #37 to 45D was obtained from the SF-12®HealthSurvey – <http://www.sf-36.org/copyright.shtml>. Permissions obtained at: Quality Metric, 640 George Washington Highway, Suite 201, Lincoln, RI 02865, Telephone: 401-334-8800 or email at license@qualitymetric.com

The next questions are about the type of health care professionals you see and the quality of the medical services you receive from your health plan.

46. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. When you joined your health plan or at any time since then, did you get a *new* personal doctor or nurse?

- ₁ Yes

No (*If no, go to question 48.*)

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

47. With the choices your health plan gave you, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

- A big problem
- A small problem
- Not a problem
- I didn't get a new personal doctor or nurse

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

48. Do you have one person you think of as your personal doctor or nurse?

Yes

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

No (*If no, skip to question 52.*)

49. Is this person:

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

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

50. Is this person part of your health plan?

- Yes
- No

51. Is this the person that you go to for most of the care related to your diabetes?

- Yes (*If yes, skip to question 54.*)
- No

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

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

53. Is this person part of your health plan?

- Yes
- No

The next few questions are about doctors that you may have seen for special health needs like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care. In answering these questions, do not include visits to your dentist.

54. In the last 12 months, did you or a doctor think you needed to see a specialist?

- Yes
- No *(If no, go to question 56.)*

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

55. In the last 12 months, how much of a problem, if any, was it to get a referral to a specialist that you needed to see?

- A big problem
- A small problem
- Not a problem at all
- I didn't need to see a specialist in the last 12 months.

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

56. In the last 12 months, did you see a specialist?

- Yes
- No *(If no, go to question 58.)*

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

57. Was the specialist you saw most often the same doctor as your personal doctor?

- Yes
- No
- I don't have a personal doctor or I didn't see a specialist in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

58. In the last 12 months, did you make any appointments with a doctor or other health provider for regular or routine health care?

- Yes
- No *(If no, go to question 60.)*

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

59. In the last 12 months, how often did you get an appointment for *regular or routine* health care **as soon** as you wanted?

- ₁ Never
- ₂ Sometimes
- ₃ Usually
- ₄ Always
- ₅ I didn't need an appointment for regular or routine care in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

60. In the last 12 months, did you have an *illness or injury* that needed care right away from a doctor's office, clinic or emergency room?

- ₁ Yes
- ₂ No (*If no, go to question 62.*)

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

61. In the last 12 months, when you needed care right away for an *illness or injury*, how often did you get care as soon as you wanted?

- ₁ Never
- ₂ Sometimes
- ₃ Usually
- ₄ Always
- ₅ I didn't need care right away for an illness or injury in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

62. In the last 12 months, how many times did you go to an emergency room to get care for yourself?

- ₁ None
- ₂ Yes _____ (*Write in number of times.*)

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

63. In the last 12 months (not counting the times you went to an emergency room), how many times did you go to a doctor's office or clinic to get care for yourself?

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

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

64. In the last 12 months, how much of a problem, if any, was it to get the care you or your doctor believed necessary?

- A big problem
- A small problem
- Not a problem at all
- I had no visits in the last 12 months.

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

65. In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

- A big problem
- A small problem
- Not a problem at all
- I had no visits in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

66. In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

67. In the last 12 months, how often was office staff at a doctor's office or clinic as helpful as you thought they should be?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the last 12 months.

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

68. In the last 12 months, how often did doctors or other health providers listen carefully to you?

- Never
- Sometimes
- Usually

- Always
- I had no visits in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

69. In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the last 12 months.

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

70. In the last 12 months, how often did doctors or other health providers show respect for what you had to say?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

71. In the last 12 months, how often did doctors or other health providers spend enough time with you?

- Never
- Sometimes
- Usually
- Always
- I had no visits in the last 12 months

***US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.**

72. Over the past twelve months, how would you rate the quality of care you received for your diabetes?

- Excellent
- Very good
- Good
- Fair
- Poor

The next questions ask about your experiences with your health plan.

73. In the last 12 months, did you call your health plan's customer service to get information or help?

Yes

No (*If no, skip to question 75.*)

**US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.*

74. In the last 12 months, how much of a problem, if any, was it to get the help you needed when

you called your health plan's customer service?

A big problem

A small problem

Not a problem

I didn't call my health plan's customer service in the last 12 months

**US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.*

75. **Paperwork** means things like getting your ID card, having your records changed, processing forms, or other paperwork related to getting care. In the last 12 months, did you have any experiences with paperwork for your health plan?

Yes

No (*If no, skip to question 77.*)

**US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.*

76. In the last 12 months, how much of a problem, if any, did you have with paperwork for your health plan?

A big problem

A small problem

Not a problem

I didn't have any experience with paperwork for my health plan in the last 12 months.

**US Agency for Healthcare Research and Quality. CAHPS Health Plan Survey 4.0: Child Medicaid Questionnaire. Washington, DC: August 2007.*

Question #77 to #81 was obtained from the ED-5Q (EuroQol) survey – <http://www.euroqol.org/>. Permissions obtained at: EuroQol Group, PO Box 4443, 3006 AK Rotterdam, The Netherlands, Telephone +31 10 408 1545 and Fax +31 10 452 5303.

The next questions are about the costs of your healthcare.

82. Some people have more than one type of insurance. Do you have any of the following types of health insurance? **Check all that apply.**

- ₁ No, I do not have any other type of health insurance
- ₂ Other private health insurance
- ₃ Medicare
- ₄ Supplemental Medicare
- ₅ Medicaid
- ₆ Veterans Administration (VA)
- ₇ Other (*please write in*) _____
- ₈ Unsure

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

- ₁ Yes
- ₂ No → *If No*, what is the main reason that you do not use <HP to pay for most of your health care needs?

CHECK UP TO THREE ITEMS

- ₁ I am covered by other health insurance (e.g., through a spouse or relative)
- ₂ I moved
- ₃ My out of pocket costs were too high
- ₄ My doctor is not in the plan
- ₅ My doctor left the plan
- ₆ I did not like the way plan doctors treated me as a person
- ₇ I was unhappy with the medical care I received
- ₈ It was too hard to get permission to see a specialist
- ₉ It was too hard to get permission for tests or treatment
- ₁₀ My health changed
- ₁₁ I did not like the way the plan handled problems/complaints
- ₁₂ I did not like the way the plan handled claims and paperwork
- ₁₃ I was unhappy with the prescription benefits/coverage
- ₁₄ I was unhappy with the medical benefits/coverage
- ₁₅ Other (*Specify*: _____)

84. Do you have to pay a co-payment, or a fixed dollar amount that you pay every time you see your regular doctor?

- ₁ Yes
- If yes, how much? (*enter amount*)\$ _____
- ₂ No

85. Do you have to pay a co-payment, or fixed dollar amount every time you see a specialist?

- ₁ Yes
- If yes, how much? (*enter amount*)\$ _____

No

86. Do you have to pay a co-payment, or fixed dollar amount every time you buy a prescription medication?

Yes

No

87. Do you have a deductible or an amount that you must pay first, before outpatient health care is a covered benefit?

Yes

→ If yes, how much? (enter amount)\$ _____

No

88. Please check the box that best describes if your insurance plan pays for all, some or none of the following equipment or supplies related to your diabetes care. If you pay a small co-pay, choose “Insurance Pays Some.”

	Insurance Pays All	Insurance Pays Some	Insurance Pays None	Unsure	Not Applicable
	1	2	3	4	5
A. Glucose monitors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Glucose strips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Insulin syringes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Insulin pens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

89. Please check the box that best describes if your insurance plan pays for all, some or none of the following services related to your diabetes care. If you pay a small co-pay, choose “Insurance Pays Some.”

	Insurance Pays All	Insurance Pays Some	Insurance Pays None	Unsure	Not Applicable
	1	2	3	4	5
A. Eye exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Nutrition counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Diabetes education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Foot doctor/ podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Psychiatrist or other mental health professional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

90. Think about the extra time **you yourself** spend taking care of your diabetes-related health problems (Related problems might include high blood pressure, high cholesterol, or heart and circulation problems). If you spend **no** extra time, please indicate “0” minutes.

On a typical day, how many extra minutes do you spend:

- A. Caring for your feet? _____ minutes
- B. Exercising? _____ minutes
- C. Shopping for and cooking special foods? _____ minutes

91. In a typical week, how many hours do **other people** (spouse, family, or friends) spend helping you with the following activities to take care of your diabetes-related health conditions:

- A. Transportation: _____ hours
- B. Getting or using medications, injections or supplies: _____ hours
- C. Foot care: _____ hours

92. In a typical week, how many days do you work for pay? _____ days
(note: if you do not work for pay, skip to question 94.)

93. During the past four weeks, because of your diabetes or related health problems, how many days were you not able to work? _____ days

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

- ₁ Less than \$5,000
- ₂ \$5,000 to under \$7,500
- ₃ \$7,500 to under \$10,000
- ₄ \$10,000 to under \$12,500
- ₅ \$12,500 to under \$15,000
- ₆ \$15,000 to under \$20,000
- ₇ \$20,000 to under \$25,000
- ₈ \$25,000 to under \$30,000
- ₉ \$30,000 to under \$35,000
- ₁₀ \$35,000 to under \$40,000
- ₁₁ \$40,000 to under \$75,000
- ₁₂ \$75,000 to under \$100,000
- ₁₃ \$100,000 and above

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

- ₁ 8th grade or less
- ₂ Some high school, but did not graduate
- ₃ High school graduate or GED
- ₄ Some college or 2-year college degree
- ₅ 4-year college graduate
- ₆ More than 4-year college degree

96. 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: _____

97. If not of Hispanic or Latino origin, 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!