DIABETES PATIENT SURVEY

Please place a check or X inside the circle that best answers each of the following que	estions:
1. For my age, my overall health is: (check one box)	
O Excellent O Very Good O Good O Fair O Poor	
2. How many years have you had diabetes? (neatly print the number of years inside the	*
Thinking about the care you have received from your CURRENT diabetes care provide provider on the following: (mark one circle on each line)	r, how would you rate your
•	Good F = Fair P = Poor
	E VG G F P
3. Diabetes care overall?	0 0 0 0 0
4. Questions about your diabetes were answered?	00000
5. Ease of reaching someone in an emergency? (if this doesn't apply, leave blank)	00000
6. Your test and laboratory results were reviewed and explained?	00000
7. Concern, courtesy, respect, sensitivity of the provider you saw?	00000
8. How often do you examine your feet? (check the box that best matches what you do)	
O Daily O Every other day O Once a week O Once a month O	Never
0. Do tala in	Y N
9. Do you take insulin?	0 0
10. When do you check your blood sugar level with a finger stick? (check one box)	1
O Never O Less than once a week O Once a	
O Two to three times a week O Once a day O Twice	a day
O More than twice a day	ΥN
11. Do you use tobacco products? (if you check "no" here, skip to question 14)	• • • • • • • • • • • • • • • • • • • •
12. If you use tobacco products, how long has it been since your provider discussed with you using tobacco products?	
O Within the past 12 months O 1 to 2 years ago O More than 2 years ago	O Never
	Y N
13. Has your provider referred you to a program to help you stop using tobacco products	
Has your provider or someone on your health care team discussed or given you inforn	nation on: Y N
14. the benefits of controlling your blood sugar?	
15. the symptoms of and treatment for high and low blood sugar?	
16. when to take your medications?	
17. how to test for and keep track of your blood sugar?	
18. how to take care of your feet?	
Has your provider or someone on your health care team discussed or given you inforn	
	Y N
19. how to plan your meals to improve your blood sugar?	
20. how to read food labels	
21. how specific foods affect your blood sugar? Page 1	0 0

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(If questions 22 to 25 do not apply to you, please skip to question 26.) If you are a woman who has the potential to become pregnant, has your provider or someone on your health care team discussed or given you information on: Ν 23. the risks of pregnancy because you have diabetes?...... 26. Which of the following BEST describes your racial background, ancestry, or origin? American Indian or Alaskan Native Asian or Pacific islander Black or African American Hispanic or Spanish White or Caucasian O Other 27. What is the HIGHEST GRADE you completed in school? \bigcirc 8th grade or less O Some high school High school graduate Some college or technical school College graduate Any post-graduate work 28. Who filled out this form? (check one box) O I filled it out with no help O I filled it out with help from family or friends I filled it out with help from a health care provider

A family member or friend filled it out with my answers (e.g., a parent completed the survey for their child)

My health care provider filled it out with my answers

Please write your comments and suggestions in the rectangle below.

Thank you for your assistance. Please return your completed survey to your provider.

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