

PATIENT HEALTH SURVEY

Thank you for completing this thorough questionnaire. Diabetes involves many aspects of life. This information helps us to help you. We look forward to being a part of your diabetes team.

General Information

Name: _____	Date: _____
Birth date: _____ Age: _____ Gender: _____	
Best phone number _____ Best time to call _____	OK to leave messages? <input type="checkbox"/> Yes <input type="checkbox"/> No
What is your preferred language? _____ spoken	_____ written
Primary Care Doctor: _____	Diabetes Doctor: _____
If you would like to be added to a confidential mailing list to receive diabetes-related updates, please <u>CLEARLY</u> write your email address here:	

Diabetes History

When diagnosed: _____ Blood glucose (sugar) on diagnosis: _____ Recent A1C/date (if known): _____
What type of diabetes do you have? <input type="checkbox"/> Don't know <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 1 (Do you wear a pump? <input type="checkbox"/> Yes <input type="checkbox"/> No) <input type="checkbox"/> Other
For women, did you have gestational diabetes or a baby weighing more than 9 pounds? <input type="checkbox"/> Yes <input type="checkbox"/> No
Any family members with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who _____
How do you feel about having diabetes?
Have you ever had diabetes education? <input type="checkbox"/> Yes <input type="checkbox"/> No When? _____ Where? _____
How would you rate your understanding of diabetes? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Does anybody help you take care of your diabetes? <input type="checkbox"/> No <input type="checkbox"/> Yes. Who? _____
What do you want to learn? <input type="checkbox"/> Healthy eating <input type="checkbox"/> Exercise guidelines <input type="checkbox"/> Monitoring glucose <input type="checkbox"/> Medication info <input type="checkbox"/> Dealing with stress <input type="checkbox"/> Problem solving <input type="checkbox"/> Reducing complication risk <input type="checkbox"/> Other:

Medical History

How would you rate your general health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
What other conditions or problems do you have? <input type="checkbox"/> blood pressure <input type="checkbox"/> cholesterol <input type="checkbox"/> heart <input type="checkbox"/> eye <input type="checkbox"/> thyroid <input type="checkbox"/> current/recent infection <input type="checkbox"/> kidney <input type="checkbox"/> sexual <input type="checkbox"/> gastrointestinal <input type="checkbox"/> nerve (neuropathy) <input type="checkbox"/> depression <input type="checkbox"/> Other
Explain any of these: _____
Major operations/recent hospitalizations: _____
Last eye exam? _____ Last foot exam? _____ Last medical exam? _____
Last dental checkup? _____ Last flu shot? _____ Last pneumonia shot? _____

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Nutrition

The Center for Diabetes Services
3801 Sacramento Street, 7th Floor
San Francisco, California 94118
Ph: (415)600-0506 Fax: (415)600-6279

PATIENT IDENTIFICATION



California Pacific
Medical Center

A Sutter Health Affiliate

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9/26/08

What is your current weight? _____ Height? _____

What is your goal weight? _____

Has your weight changed in the past year? Yes No _____ pounds (gained lost)

Do you have a history of an eating disorder? Yes No (describe) _____

Who cooks? _____ Who shops? _____

How often do you eat out and where? _____

What special food plan or diet do you follow (including any cultural/religious diet restrictions, if any)? Type _____

What changes have you made in your diet recently, if any _____

Do you count carbohydrates? Yes No I don't understand the question

List any food allergies or intolerances _____

Diet History (what foods do you usually eat). **List types and amounts.**

Breakfast	Lunch	Dinner
Snacks:		

Exercise

Have you been advised to limit exercise? Yes No (describe) _____

Do you exercise on a regular basis? Yes No Type _____

How many times a week do you exercise? _____ For how long? _____ minutes

Pain Assessment

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Are you having any pain now? Yes No (skip this section)
 Where is the pain? _____ Describe _____
 Are you under the doctor's care for pain? Yes No

Current Level of Pain: (circle the number that reflects the intensity)

0	1	2	3	4	5	6	7	8	9	10
None	Mild	Moderate	Severe	Very Severe	Worst Possible					
Annoying	Uncomfortable	Distressing	Horrible	Excruciating	Agonizing					

What is your goal? comfortable increase function able to sleep reduce intensity
 What do you do to manage the pain?

Monitoring

Do you test your blood glucose (sugar)? Yes. My type of meter is _____
 No (skip to "Lows" below)

What do you consider an acceptable blood glucose reading? _____
 How often do you test? _____ What time(s) of the day? _____
 Usual blood glucose before meals: _____ Two hours after meals: _____

Lows

Have you ever had low blood glucose? Never (skip to "Highs" below) When? _____

Can you feel when your glucose is too low? No Yes, my symptoms: _____

How do you treat low blood glucose? _____

Do you wear a medical identification bracelet or necklace? Yes No

Have you ever been unconscious from low glucose? No Yes When? _____

Do you have a Glucagon kit at home for severe lows? No Yes. Who in your household has been taught how to use it? _____

Highs

What are your current levels of high blood glucose? I don't know _____

How do you treat the highs? _____

Do you test for ketones? Yes No

Pregnancy (if applicable)

Are you pregnant? No Yes Expected due date? _____

Are you planning to become pregnant? Yes No Birth control method? _____ N/A

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Risk Factors

Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you told you snore?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you sleepy during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoke or exposure to cigarettes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, number of cigarettes each day_____
Do you drink alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, how much?_____
Do you use illicit drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No If yes, explain_____

Health Beliefs

I believe following my diet is the best thing I can do to control my diabetes.	_____ Agree	_____ Neutral	_____ Disagree
I have some control over whether or not I get complications of diabetes.	_____ Agree	_____ Neutral	_____ Disagree
I feel diabetes is the one of the worst things that ever happened to me.	_____ Agree	_____ Neutral	_____ Disagree
I will have to or have given up many things because of my diabetes.	_____ Agree	_____ Neutral	_____ Disagree
If I don't take care of myself, I believe diabetes could be a great threat to my life.	_____ Agree	_____ Neutral	_____ Disagree

Social/Learning History

How do you learn best (check all that apply)?
<input type="checkbox"/> Reading <input type="checkbox"/> Demonstration <input type="checkbox"/> Hands on <input type="checkbox"/> Watching TV
Do you have difficulty with: <input type="checkbox"/> Hearing <input type="checkbox"/> Speech <input type="checkbox"/> Vision <input type="checkbox"/> Mobility <input type="checkbox"/> Sitting for 2 hours or more
<input type="checkbox"/> Concentrating Explain:_____
Last Grade in School? _____
How would you describe the amount of stress in your life? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High
How do you handle it? _____
Do you have any financial concerns or worries?_____
Do you work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, type of work? _____
Work hours? _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed
Number in Household? _____ Living situation _____
Have you signed an advanced directive or medical power of attorney? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>(Optional)</i> Race/Ethnicity _____ (for data collection purposes only)
What else you would like us to know about you? _____
Your expectations of our diabetes program _____
Signature: _____

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