

## 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?  Yes  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 **CLEARLY** 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?  
 Don't know  Type 2  Type 1 (Do you wear a pump?  Yes  No)  Other  
For women, did you have gestational diabetes or a baby weighing more than 9 pounds?  Yes  No  
Any family members with diabetes?  Yes  No If yes, who \_\_\_\_\_  
How do you feel about having diabetes?  
Have you ever had diabetes education?  Yes  No When? \_\_\_\_\_ Where? \_\_\_\_\_  
How would you rate your understanding of diabetes?  Good  Fair  Poor  
Does anybody help you take care of your diabetes?  No  Yes. Who? \_\_\_\_\_  
What do you want to learn?  Healthy eating  Exercise guidelines  Monitoring glucose  
 Medication info  Dealing with stress  Problem solving  Reducing complication risk  
 Other:

### Medical History

How would you rate your general health?  Excellent  Good  Fair  Poor  
What other conditions or problems do you have?  
 blood pressure  cholesterol  heart  eye  thyroid  current/recent infection  
 kidney  sexual  gastrointestinal  nerve (neuropathy)  depression  
 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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California Pacific  
Medical Center

A Sutter Health Affiliate

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San Francisco, California 94118  
Ph: (415)600-0506 Fax: (415)600-6279

PATIENT IDENTIFICATION

**PATIENT HEALTH SURVEY**

9/26/08

### Nutrition

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

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)

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
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
<b>(Optional)</b> Race/Ethnicity _____ (for data collection purposes only)
What else you would like us to know about you? _____
Your expectations of our diabetes program _____ CDS
Signature: _____

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