

# Diabetes Health Survey

Please use a pencil or a pen with blue or black ink. Answer every question by marking the choice as indicated below. If you are unsure about how to answer a question, please mark the best available option.

Please shade Circles Like This ●

Not Like This ⊗ ○

1. Do you currently use testing strips to check your blood sugar?

Yes

If Yes, Please Continue From Question 2.

No

If No, Please Continue From Question 4.

2. Where do you get your test strips?  
(Please choose only one option)

VA only

Non-VA source only

Both VA and non-VA

3. In an average WEEK, how often do you do blood sugar testing on yourself?  
(Please choose only one option)

Less than once a week

Once or twice a week

Once a day

Twice a day

More than twice a day

4. In the past 6 MONTHS, which medicines have you taken for your diabetes?  
(Please fill in all that apply)

Glyburide (Micronase, Diabeta)

Metformin (Glucophage)

Glipizide (Glucotrol)

Rosiglitazone (Avandia)

Tolazamide

Pioglitazone (Actos)

Glimepiride (Amaryl)

Insulin

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## Diabetes Health Survey

5. Were you using glucose testing strips 6 months ago?

Yes

If Yes, please continue from Question 6

No

If No, please continue from Question 7

6. If Yes, how often were you using test strips at that time?

(Please choose only one option)

Less than once a week

Once or twice a week

Once a day

Twice a day

More than twice a day

7. Some symptoms of low blood sugar (hypoglycemia) might include feeling sweaty, confused, dizzy, lightheaded or faint. You might have your own unique symptoms of low blood sugar. In the past 6 MONTHS, have you had any low blood sugar reactions (hypoglycemia)?

Yes

If Yes, please continue from Question 8.

No

If No, This completes your survey!  
Thank-you for your help. Please return the survey in the enclosed envelope.

Now think of the WORST low blood sugar reaction you had in the past 6 months. The following questions are about your WORST low blood sugar reaction.

8. Did you need someone to help you treat your WORST low blood sugar reaction?

Yes

No

9. If yes, who helped you?

(Please check all that apply)

Family member or friend

Bystander

Paramedics

Doctor or Nurse

Doesn't apply; did not need help

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# Diabetes Health Survey

10. Did you need to go to an Emergency Department, hospital or clinic for treatment?

Yes

No

If No, Please go to questions 13 and 14 to complete the survey.

11. If Yes, did you go to a VA Emergency Department, hospital, Doctor's office or clinic for treatment?

Yes

No

If No, Please continue from question 13.

12. Did you have to stay overnight in a hospital for treatment?

Yes

No

If No, this completes your survey! Thank-you for your help. Please return the survey in the enclosed envelope.

13. During the two weeks right before your worst low blood sugar reaction, were you doing blood sugar testing on yourself?

Yes

No

14. If Yes, on average, how often WERE you doing blood glucose testing on yourself during those two weeks before your worst low blood sugar reaction?

(Please choose only one option)

Less than once a week

Once or twice a week

Once a day

Twice a day

More than twice a day

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