DIABETES QUESTIONNAIRE

HomeopathicVibes
940 E. El Camino Real
Sunnyvale, CA 94087
harminder@homeopathicvibes.com
www.homeopathicvibes.net
Office (408)737-7100

Patient Name: ________________________________Age:____ Date of Birth: _____________Sex: M__ F__

Home Adress___________________________City____________________State_____Zip Code____________

Ethnicity: ( ) Caucasian ( ) Hispanic ( ) Native American ( ) African-American ( ) Other

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY. Base your answers on your own observations and not on what others have told you or what you may have assumed on the basis of previous tests.

Background

1. What are the problems that bring you to this office?

____

____

2. Are you currently (check one only)
Married ( ) Single ( ) Separated ( ) Widowed ( ) Divorced ( ) Separated ( )

3. Please indicate which chronic condition(s) you have
Type 1 diabetes ( ) Type2 diabetes ( ) High Cholesterol ( ) Hypertension( )

Heart disease. ( )
Lung disease ( )

Others specify: ____

4. In general how would you rate your health

Excellent ( )
Very good ( )
Good ( )
Fair ( )

Poor ( )

General Health

5. How many times(approx) in last month? Please circle one number.

	None	**A little**	**Some what**	**A good bit**	**Most of**	**All the time**
a. Were you discouraged by your health issue?	0	1	2	3	4	5
b. Were you fearful about your future health?	0	1	2	3	4	5
c. Was your health a worry in your life?	0	1	2	3	4	5
d. Were you frustrated by your health problem?	0	1	2	3	4	5
e. Were you tied energy wise or fatigued?	0	1	2	3	4	5
f. Were you having pain in your legs or feet?	0	1	2	3	4	5
g. Were you having shortness of breath?	0	1	2	3	4	5

6. In the PAST WEEK, did you have any of the following symptoms?

	Yes	**No**
Increased thirst	( )	( )
Dry mouth	( )	( )
Decreased appetite	( )	( )
Nausea or vomiting	( )	( )
Abdominal pain	( )	( )
Frequent urination	( )	( )
Nightmares	( )	( )
Night sweats	( )	( )
Lightheadedness	( )	( )
Shakiness or weakness	( )	( )
Intense hunger	( )	( )
Fainted, passed out or lost consciousness	( )	( )

Daily Activities

During last 4 weeks: Circle one only.

1. Has your health interfered with your normal social activities with family friends or neighbors or groups?

Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost Always**
0	1	2	3	4

2. Has your health interfered with your hobbies or recreational activities?

Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost Always**
0	1	2	3	4

3. Has your health interfered with your household chores?

Not at all **Slightly** **Moderately** **Quite a bit** **Almost Always**

0 1 2 3 4

4. Has your health interfered with your errand and shopping?

Not at all	Slightly	Moderately	Quite a bit	Almost Always
0	1	2	3	4

Your Glucose Testing

1. Do you have a machine to measure your blood glucose level? Yes ( ) No ( )

2. How many days in last week did you check your blood glucose level ____________days

3. On day you checked your blood glucose, how many times do you test on average. ___________times

Physical Activities

During past week, even if was not a typical week for your how much total time (for the entire week) did you spend on each of the following.

	None	less than 30min	30-60mins	1-3 hours	more than 3 hr/wk
Stretching or strengthening exercises	0	1	2	3	4
Walk or exercises……………………..	0	1	2	3	4
Swimming or aquatic exercise………	0	1	2	3	4
Bicycling including stationary………...	0	1	2	3	4
Aerobic (stair master, rowing etc.)…….	0	1	2	3	4
Any other__________specify…………	0	1	2	3	4

Confidence about doing things

For each of the following question, please circle the number that better corresponds with your confidence level.

1. **How confident** do you feel that you can eat your meals every 4-5 hours everyday including breakfast.

Not at all Confident ____ **Very Confident**

1 2 3 4 5 6 7 8 9 10

2. **How confident** do you feel when eat your meals with others who are not diabetics?

Not at all Confident ____ **Very Confident**

1 2 3 4 5 6 7 8 9 10

3. **How confide**nt do you feel that you can choose appropriate foods when hungry (for example snacks etc.)?

Not at all Confident ____ **Very Confident**

1 2 3 4 5 6 7 8 9 10

4. **How confident** do you feel that you can exercise 15 to30 minutes, 4-5 times a week?

Not at all **Very**

Confident ______________________________________ **Confident**

1	2	3	4	5	6	7	8	9	10

5. **How confident** do you feel that you can do something to prevent your blood sugar level dropping when you exercise?

Not at all **Very**
Confident ______________________________________ **Confident**

1	2	3	4	5	6	7	8	9	10

6. How confident do you feel that you can do something to lower your blood sugar level when it goes higher or lower than it should be?

Not at all **Very**
Confident ______________________________________ **Confident**

1	2	3	4	5	6	7	8	9	10

7. How confident do you feel that you can do something to prevent your blood sugar level dropping when you exercise?

Not at all **Very**
Confident ______________________________________ **Confident**

1	2	3	4	5	6	7	8	9	10

8. How confident do you feel that you can control your diabetes so that it does not interfere with the things you want to do?

Not at all **Very**
Confident ______________________________________ **Confident**

1	2	3	4	5	6	7	8	9	10

Your Diet

1. How many times **last week** did you eat breakfast when you wake up? ____________times last week.

2. **This morning** did you eat any of the following food for breakfast?

	Yes	**No**
Milk ½ cup	( )	( )
Cheese	( )	( )
Yogurt	( )	( )
Eggs	( )	( )
Meat or poultry	( )	( )
Beans	( )	( )

Medications

	Yes	**No**	**Don't know**
1. Did you take pills for diabetes past week?	( )	( )	( )

Please specify the names of pills you took____

2. In the past week did you get any insulin injections? ( )   ( )   ( )

3. Please specify the name of blood pressure pills you took____________________________________

4. In the past week did you took any cholesterol pill?( )   ( )   ( )

4. Please specify the name of cholesterol pills you took_______________________________________

Medical care

When visiting your doctor how often do you do the following?

	Never	**Almost Never**	**Sometimes**	**Fairly often**	**Very often**	**Always**
1. Prepare a list of questions to ask……….	0	1	2	3	4	5
2. Ask questions about the things you want to know about your treatment………………..	0	1	2	3	4	5
3. Discuss any personal problem that many relate to your illness…………………………	0	1	2	3	4	5

4. **In past six months** how many times did you visit a doctor?........................... ________visits.

5. **In past six months** how many times did you visit an **emergency department in a hospital**?.......... ________visits.

6. **In past six months** how many total Nights you spent in a hospital?........... ________Nights

7. **When was last time you had your eyes examined?** (for glaucoma or any other problems)

________ Month   ________ Year

8. How many time doctor or nurse examined your feet **in past six months**?…….. ________times.

HOMEOPATHICVIBES CONSULTANT NOTES.