Proxy 2008

MEPS
Medical Expenditure Panel Survey

A Survey About Diabetes Care

The care of people with diabetes is an important concern of the U.S. Department of Health and Human Services. We would appreciate it if you would take a few minutes to answer the following questions on the care your family member received for his or her diabetes. Your participation is voluntary and all of the answers will be kept confidential. If you have any questions about this survey, please call Alex Scott at 1-800-945-MEPS (6377).

This survey should be completed for

NAME: _____

_____ _____

DOB: _____ **PID:** _____

RUID: _____

When you have completed the survey, please fold it, seal it with this label, and place it in the envelope provided.

The Agency for Healthcare Research and Quality and
The Centers for Disease Control and Prevention of the
U.S. Department of Health and Human Services

A Survey About Your Diabetes Care

Instructions: Answer every question by checking one box ☑ or filling in a number as indicated. If you are unsure about how to answer a question, please give the best answer you can. **In the questions below, "(NAME)" refers to the person listed in the box on the front page**.

1. Has (NAME) **ever** been told by a doctor or other health professional that he/she has diabetes or sugar diabetes? (CHECK ONE)

   Yes ..... ☐ 1

   ➡**Please continue.**

   No ..... ☐ 2

   ➡**Thank you for your time. This survey is complete.**

2. During 2007, how many times did a doctor, nurse, or other health professional check (NAME)'s **blood** for glycosylated hemoglobin or "hemoglobin A-one-C?"

   *(A1C is a blood test that is primarily done to monitor the glucose level of diabetics. Please note that this is a blood test which has to be done in a lab, hospital, or doctor's office; this is **NOT** a test which you can perform at home.)*

   If (NAME) had this blood test, fill in number of times ..... ____

   Did not have A1C blood test..... ☐ 96

   Don't know..... ☐ 98

   Never..... ☐ 00

3. During 2007, how many times did a health professional check (NAME)'s feet for any sores or irritations? (FILL IN NUMBER OF TIMES)

   Number of Times ..... ____

   Never..... ☐ 00

4. Which of the following year(s) did (NAME) have an eye exam in which his/her pupils were dilated? This would have made him/her temporarily sensitive to bright light. (CHECK ALL THAT APPLY)

   During 2008 ..... ☐ 1

   During 2007 ..... ☐ 2

   During 2006 ..... ☐ 3

   Before 2006 ..... ☐ 4

   Never..... ☐ 00

5. Has (NAME)'s diabetes caused problems with his/her kidneys?

   Yes ..... ☐ 1

   No..... ☐ 2

6. Has (NAME)'s diabetes caused problems with his/her eyes that needed to be treated by an ophthalmologist?

   Yes ..... ☐ 1

   No..... ☐ 2

7. Is (NAME)'s diabetes being treated by modifying his/her diet?

   Yes ..... ☐ 1

   No..... ☐ 2

This survey is part of the Medical Expenditure Panel Survey, conducted by the U.S. Department of Health and Human Services. This survey is authorized under Section 902(a) of the Public Health Service Act [42 U.S.C. 299a]. The confidentiality of personal information is protected by Federal Statutes, Section 924(c) and Section 308(d) of the Public Health Service Act [42 U.S.C. 299c-3(c) and 242m(d)]. This law prohibits release of personal information outside the public health agencies sponsoring the survey or their contractors without first obtaining permission from the person who gave the information. The Federal government requires that all persons asked to respond to one of its surveys be given the following information: Public reporting burden for this collection of information is estimated to average 5 minutes per interview, the estimated time required to complete the "A Survey About Your Diabetes Care." Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to:

Reports Clearance Officer
Attention: PRA, United States
Public Health Service
Paperwork Reduction Project (0935-0098)
Hubert H. Humphrey Building, Room 721-B
200 Independence Avenue, SW
Washington, DC 20201

8. Is (NAME)'s diabetes being treated by medications taken by mouth?

Yes ..... ☐ 1
No..... ☐ 2

9. Is (NAME)'s diabetes being treated with insulin injections?

Yes ..... ☐ 1
No..... ☐ 2

10. During the last 6 months, has (NAME) received any of the following to teach him/her how to take care of his/her diabetes:

Telephone call to his/her house
Yes ..... ☐ 1
No..... ☐ 2

Appointment with nurse
Yes ..... ☐ 1
No..... ☐ 2

Visit to his/her home
Yes ..... ☐ 1
No..... ☐ 2

Referral to a specialist
Yes ..... ☐ 1
No..... ☐ 2

11. About how long has it been since (NAME) had his/her blood cholesterol checked by a doctor or other health professional?

WITHIN PAST YEAR..... ☐ 1
WITHIN PAST 2 YEARS..... ☐ 2
WITHIN PAST 3 YEARS..... ☐ 3
WITHIN PAST 5 YEARS..... ☐ 4
MORE THAN 5 YEARS ..... ☐ 5
NEVER..... ☐ 00

12. About how long has it been since (NAME) had a flu vaccination (shot or nasal spray)?

WITHIN PAST YEAR..... ☐ 1
WITHIN PAST 2 YEARS..... ☐ 2
WITHIN PAST 3 YEARS..... ☐ 3
WITHIN PAST 5 YEARS..... ☐ 4
MORE THAN 5 YEARS ..... ☐ 5
NEVER..... ☐ 00

Thank you for taking the time to complete this important survey.

Please remember to fold it, seal it, and place it in the envelope provided.

Date complete _____

Who completed the survey for the person named on the front page?

_____

What is your relationship to the person named on the front page?

_____

_____

_____

23283.1107.76904403

Data Year 2007
08-231

OMB #0935-0118