



A Survey About Your Diabetes Care

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

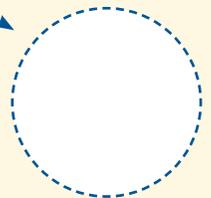
This survey should be completed by 

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.

1. Have you **ever** been told by a doctor or other health professional that you have 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 your **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 you 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 your feet for any sores or irritations? (FILL IN NUMBER OF TIMES)

Number of Times _____

Never 00

4. Which of the following year(s) did you have an eye exam in which your pupils were dilated? This would have made you 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 your diabetes caused problems with your kidneys?

Yes 1

No 2

6. Has your diabetes caused problems with your eyes that needed to be treated by an ophthalmologist?

Yes 1

No 2

7. Is your diabetes being treated by modifying your 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 your diabetes being treated by medications taken by mouth?
 Yes 1
 No..... 2
9. Is your diabetes being treated with insulin injections?
 Yes 1
 No..... 2
10. During the last 6 months, have you received any of the following to teach you how to take care of your diabetes:
- Telephone call to your house**
 Yes 1
 No..... 2
- Appointment with nurse**
 Yes 1
 No..... 2
- Visit to your home**
 Yes 1
 No..... 2
- Referral to a specialist**
 Yes 1
 No..... 2

11. About how long has it been since you had your 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 you 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 completed _____

If this survey was not completed by the person named on the front page, who completed the survey? _____

What is this person's relationship to the person named on the front page?

What is the reason the person named on the front page did not complete the survey himself/herself? _____



