

Section 12: Diabetes Mellitus

Questionnaire

12.1	Have you ever been told by a doctor, nurse, or other health professional that you had or have diabetes or high blood sugar?	1. Yes		<input type="checkbox"/>	12.5
		2. No		<input type="checkbox"/>	
		3. Don't recall/not sure		<input type="checkbox"/>	
12.2	V. 1.1 si F ↓ M → 12.3 Were you informed you had diabetes when you were pregnant?	1. Yes	<input type="checkbox"/>	3. Don't recall/not sure	<input type="checkbox"/>
		2. No	<input type="checkbox"/>		
12.3	Are you currently in some type of program or receiving treatment to control your diabetes/glycemia/blood sugar?	1. Yes		<input type="checkbox"/>	12.5
		2. No		<input type="checkbox"/>	
12.4	What type of treatment are you following?	1. Medication		<input type="checkbox"/>	
		2. Treatment without medication (diet, exercise, weight control)		<input type="checkbox"/>	
12.5	Has anyone, on at least one occasion, tested (taken/checked) your blood sugar/glycemia prior to this interview?	1. Yes		<input type="checkbox"/>	13.1
		2. No		<input type="checkbox"/>	
		3. Don't recall/not sure		<input type="checkbox"/>	
12.6	When was the last time your blood sugar/glycemia was tested?	1. More than 6 months ago		<input type="checkbox"/>	
		2. 6-12 months ago		<input type="checkbox"/>	
		3. More than 12 months ago		<input type="checkbox"/>	
		4. Don't recall/not sure		<input type="checkbox"/>	



12.7	<i>What kind of treatment <u>that does not involve medication</u> are you following to lower/control your diabetes/glycemia?</i>	1. Fat-free diet or your diet contains less fat than previously	<input type="checkbox"/>	
		2. Regular physical exercise	<input type="checkbox"/>	
		3. Weight loss or control	<input type="checkbox"/>	
		4. Increasing your intake of fruits and vegetables	<input type="checkbox"/>	
		5. Other	<input type="checkbox"/>	
		6. None	<input type="checkbox"/>	
12.8	About how often do you—a family member or friend—do in-home testing to determine your BLOOD glucose/sugar levels (do not include times your doctor or other health professional performed these tests)?	1. Times per day		
		2. Times per week		
		3. Times per month		
		4. Times per year		
		5. Never	<input type="checkbox"/>	
		6. Don't recall/not sure	<input type="checkbox"/>	
12.9	Please show me the diabetes medication you're taking. The interviewer will ask the respondent to show any medication he/she is taking. The interviewer will then write down, in the spaces provided below, the name(s) of the medications as they appear on the product label. Staff trained in this area will be responsible for classifying medication into groups.	1.		
		2.		
		3.		
		4.		
		5.		
		6.		
12.10	Have you heard of glycosylated hemoglobin or hemoglobin "A1c"?	1. Yes		
		2. No		
		3. I'm not sure		



12.11	Approximately how many times during the past year has a doctor, nurse or other health professional tested you for or told you about glycosylated hemoglobin?		1. Number of times		
			2. Never		
			3. Don't recall/not sure		
12.12	Is the medication prescribed by your doctor generally available (on the market)?	1. Yes, always	<input type="checkbox"/>	3. Yes, but very difficult to get.	<input type="checkbox"/>
		2. Yes, but sometimes difficult to get	<input type="checkbox"/>	4. I am unable to get it	<input type="checkbox"/>
12.13	Are you generally able to afford or have the means to buy the medication prescribed by your doctor?	1. Yes, always	<input type="checkbox"/>	3. Yes, but buying them presents a hardship.	<input type="checkbox"/>
		2. Yes, but buying is sometimes presents a hardship	<input type="checkbox"/>	4. I cannot afford them	<input type="checkbox"/>

