New Jersey Department of Health
Office of Minority and Multicultural Health

DIABETES SELF-MANAGEMENT PROGRAM

"TAKE CONTROL OF YOUR HEALTH"
PRE-WORKSHOP PARTICIPANT SURVEY

ID Number: _____ Date: _____ Zip Code: _____

Sex *(Check)*: ☐ Female ☐ Male

What is your age group?

☐ Under 25
☐ 25 - 34
☐ 35 - 44
☐ 45 - 54
☐ 55 - 64
☐ 65+

Are you Hispanic, Latino/a, or Spanish origin?
(Check all that apply)

a. ☐ Mexican, Mexican American, Chicano/a
b. ☐ Puerto Rican
c. ☐ Cuban
d. ☐ Another Hispanic, Latino, or Spanish origin

What is your race? *(Check all that apply)*

a. ☐ White
b. ☐ Black or African American
c. ☐ American Indian or Alaska Native
d. ☐ Asian Indian
e. ☐ Chinese
f. ☐ Filipino
g. ☐ Japanese
h. ☐ Korean
i. ☐ Vietnamese
j. ☐ Other Asian
k. ☐ Native Hawaiian
l. ☐ Guamanian or Chamorro
m. ☐ Samoan
n. ☐ Other Pacific Islander

Are you currently: *(check only one)*

☐ Married
☐ Single
☐ Separated
☐ Divorced
☐ Widowed
☐ Partnered (living with someone)

What level of education did you complete?
(check only one)

☐ Less than high school
☐ Some high school
☐ High school graduate
☐ Some college or vocational school
☐ College graduate
☐ Graduate school

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Has a doctor or nurse ever told you that you are sick because you have:
(Check all that apply.)

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Arthritis/Rheumatic Disease
- ☐ Breathing/ Lung Disease (e.g., Asthma, Emphysema, Bronchitis)
- ☐ Heart Disease
- ☐ Hypertension (High Blood Pressure)
- ☐ Cancer
- ☐ Stroke
- ☐ Depression or Anxiety Disorder
- ☐ Osteoporosis
- ☐ Other Chronic Condition: _____
- ☐ None (No Chronic Conditions)

Monitoring Sugar Level			
1.	Do you have a machine to test your blood sugar (glucose) level at home?	☐ Yes	☐ No
2.	**If yes**, how many days in the last week did you test your blood sugar level? (If you were sick in the last week, think of the most recent 7 days when you were NOT sick).	_____ days	
3.	Do you know what the results mean?	☐ Yes	☐ No
4.	Have you had a Hemoglobin A1c test in the past month?	☐ Yes	☐ No

I. In general, would you say your health is: *(check only one)*

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

II. In the PAST WEEK, did you ever have any of the following symptoms: *(Check only one)*				
1.	Increased thirst?	☐ Yes	☐ No	☐ Don't Know
2.	Dry mouth?	☐ Yes	☐ No	☐ Don't Know
3.	Decreased need for food?	☐ Yes	☐ No	☐ Don't Know
4.	Sickness in stomach or vomiting?	☐ Yes	☐ No	☐ Don't Know
5.	Belly pain?	☐ Yes	☐ No	☐ Don't Know
6.	Do you have to get up to urinate 3 or more times a night?	☐ Yes	☐ No	☐ Don't Know
7.	High blood sugar readings (300 mg or higher)?	☐ Yes	☐ No	☐ Don't Know
8.	Morning headaches?	☐ Yes	☐ No	☐ Don't Know
9.	Bad dreams?	☐ Yes	☐ No	☐ Don't Know
10.	Night sweats?	☐ Yes	☐ No	☐ Don't Know
11.	Lightheadedness or dizziness?	☐ Yes	☐ No	☐ Don't Know
12.	Shakiness or weakness?	☐ Yes	☐ No	☐ Don't Know
13.	Severe hunger?	☐ Yes	☐ No	☐ Don't Know
14.	Times when you fainted or passed out, even for a short time?	☐ Yes	☐ No	☐ Don't Know

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III. Daily Activities		***(Circle one)***				
		Not at all	**Slightly**	**Moderately**	**Quite a bit**	**Almost totally**
1.	**During the past 2 weeks,** how much has your sickness stopped you from being with family, friends, neighbors or groups?	**0**	**1**	**2**	**3**	**4**
2.	**During the past 2 weeks,** how much has your sickness stopped you from doing things you enjoy like reading, playing sports or other fun things?	**0**	**1**	**2**	**3**	**4**
3.	**During the past 2 weeks,** how much has your sickness stopped you from doing everyday work around your house (e.g. cleaning, cooking etc.)?	**0**	**1**	**2**	**3**	**4**
4.	**During the past 2 weeks,** how much has your sickness stopped you from doing other things that you need to do such as shopping?	**0**	**1**	**2**	**3**	**4**

IV. Controlling My Sickness For each of the following questions, please ***circle one*** number for each question that tells how you feel about doing things easily at this time:		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1.	I eat meals every 4 to 5 hours every day, including breakfast every day.	**1**	**2**	**3**	**4**	**5**
2.	I follow my diet and know what to eat when I am hungry.	**1**	**2**	**3**	**4**	**5**
3.	I exercise 15 to 30 minutes, 4 to 5 times a week.	**1**	**2**	**3**	**4**	**5**
4.	I know how to stop my blood sugar level from falling when I exercise.	**1**	**2**	**3**	**4**	**5**
5.	I know what to do when my blood sugar level goes higher or lower than it should be	**1**	**2**	**3**	**4**	**5**
6.	Feeling tired from being sick does not stop me from doing things that I want to do.	**1**	**2**	**3**	**4**	**5**
7.	Fear or worry from being sick does not stop me from doing things I want to do.	**1**	**2**	**3**	**4**	**5**
8.	I know my medications and take them every day.	**1**	**2**	**3**	**4**	**5**
9.	I go for all my doctor appointments needed for my treatment.	**1**	**2**	**3**	**4**	**5**
10.	I know when the changes in my sickness mean I should go to my doctor.	**1**	**2**	**3**	**4**	**5**

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V. During the past week, how much total time did you spend on the following: *(check only one)*		**None**	**Less than 30 min/wk**	**30 - 60 min/wk**	**1 – 3 hrs/wk**	**More than 3 hrs/wk**
1.	Stretching or using weights	**1**	**2**	**3**	**4**	**5**
2.	Walking for exercise	**1**	**2**	**3**	**4**	**5**
3.	Swimming	**1**	**2**	**3**	**4**	**5**
4.	Using exercise machine	**1**	**2**	**3**	**4**	**5**

VI. Your Diet		
1.	How many times last week did you eat breakfast when you got up?	_____ **times**
2.	This morning, did you eat any of the following foods for breakfast? *(check all that apply)* ☐ Milk (1/2 cup) ☐ Cheese ☐ Yogurt ☐ Eggs ☐ Meat, poultry, or fish ☐ Beans If you ate anything else, please write here: _____	

VII. Medications				
1.	In the past week did you take pills for diabetes?	☐ Yes	☐ No	☐ Don't Know
2.	Please specify the name(s) of the diabetes pills you took: _____			
3.	In the past week did you get insulin injections?	☐ Yes	☐ No	☐ Don't Know

VIII. Medical Care When you **go to your doctor**: *(please circle one number for each question)*		*(Circle one)*					
		Never	**Almost never**	**Some-times**	**Fairly often**	**Very often**	**Always**
1.	Do you make a list of questions for your doctor?	**0**	**1**	**2**	**3**	**4**	**5**
2.	Do you ask questions about the things you want to know and things you don't understand?	**0**	**1**	**2**	**3**	**4**	**5**
3.	Do you talk about things other than your being sick?	**0**	**1**	**2**	**3**	**4**	**5**

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VIII. Medical Care, Continued		
4.	In the past 2 months, how many TIMES did you visit a doctor? *(Do **not** include hospital or ER visits)*	_____ **times**
5.	In the past 2 months, how many TIMES did you go to a walk-in-clinic for an emergency?	_____ **times**
6.	In the past 2 months, how many TIMES did you go to a hospital emergency room?	_____ **times**
7.	In the past 2 months, how many TIMES were you admitted to the hospital for one night or longer?	_____ **times**
8.	When was the last time you had your eyes examined? (example: for glaucoma or any other problem)	_____ **/** _____ **Month / Year**
9.	How many times did the doctor or nurse examine your feet in the last 6 months?	_____ **times**

IX. Check all that apply:		
I am a participant with a sickness.	☐ Yes	☐ No
I take care of someone with a sickness.	☐ Yes	☐ No

X. Have you ever taken this class before?		
☐ Yes	☐ No	☐ Unsure

XI. This survey was completed: *(check only one)*	
☐ Without help	☐ With some help

Thank you for completing the survey!