ANNEXURE-6
DIABETES SCREENING QUESTIONNAIRE

Name:_____________ Weight:_______ Height:______
Age: ___________ Sex:____________
Occupation: _______________________
Address: __________________________
____________________________________
Tel. No.: 

1. When were you first diagnosed with diabetes? Year_____Age ________

2. Have you ever been diagnosed for
   • High blood pressure? ______Yes ______No
     If Yes, are you taking any medicine for high blood pressure?
   • High cholesterol/ abnormal amount of fat in your body? _____Yes_____No
     If Yes, are you taking medicine for high cholesterol?
   • Any kidney disease? ______Yes ______No
     If yes, is it retinopathy/ macular edema/ vision problem?
   • Any chest pain history? ______ Yes_____ No
   • Any other major illness/ medical condition? _____Yes _____ No
     If yes, is it,
     Numbness/tingling in extremities
     Burning or pain in the feet
     Decreased sensation to a body part.
     Loss of sensation to a body part
     Diagnosed diabetic ulcer.
     Foot ulcer

3. In the last six months, have you been admitted to a hospital for any reason?
   ______Yes ______No
   If yes, please describe:

4. In the past six months, have you had any severe hypoglycemia, i.e., very low blood sugar that required you to get help? _____Yes _____No
   If yes, how many times?
   How many times were you given an injection of glucagon?
   How many times did you need to stay overnight at a hospital?
5. In the past six months, have you had ketoacidosis (frequently associated with high blood sugar, vomiting and shortness of breath)?
   _____ Yes _____ No
   If yes, how many times?
   How many times did this result in hospital stay?

6. Medication history
   Are you currently being treated with insulin? _____ Yes _____ No
   Were you ever been treated with insulin since you were diagnosed?
   _____ Yes _____ No
   What prescribed medications are you currently taking?

7. Are you following any diet plan? _____ Yes _____ No
   If yes, please give details:

8. Do you exercise? _____ Yes _____ No
   If yes, do you exercise regularly?
   How many times per week?
   Type of exercise?
   Any problem with exercise related to low blood sugar?

9. Do you have a family history of diabetes? _____ Yes _____ No

10. Habits
    • Smoking cigarettes _____ Yes _____ No
       If yes, how many cigarettes per day?
       From how long, are you smoking?
       If stopped smoking, how long ago?
    • Do you consume alcohol? _____ Yes _____ No
       If yes, how much?
       And, how often?

11. Medical reports, if any?