

# My Diabetes GOAL Survey

Record ID \_\_\_\_\_

**Welcome to the My Diabetes Goals Survey. The purpose of this survey is to learn about your preferences or concerns about managing diabetes. Diabetes can also be called high sugars or "sugars". We want to know how these might affect your medication choices, safety, and overall health. Each person with diabetes has different goals. These goals can depend on your health and your personal preferences. This survey should take less than 15 minutes to complete. Besides helping to identify your goals, we can also help connect you with services to help you reach your goals.**

**So we are going to create a plan for your goals. First though, we have to ask you some basic questions about your health. If you are helping someone complete this survey, please answer the questions with the patients' responses. For example, when answering a question about your age, please complete the survey with the age of the patient. Our diabetes health care manager will then be in touch with you to review your goals after the survey has been completed.**

**If you have any questions, please contact the study manager, Aviva Nathan, at 773-702-9521 or email [anathan@bsd.uchicago.edu](mailto:anathan@bsd.uchicago.edu).**

What is your age?

- ☐ 59 or younger  
☐ 60-64  
☐ 65-69  
☐ 70-74  
☐ 75-79  
☐ 80-84  
☐ 85 or older

What is your sex?

- ☐ Male  
☐ Female

How tall are you? \_\_\_\_ feet

\_\_\_\_ inches

\_\_\_\_\_

\_\_\_\_\_

How much do you weigh? (in pounds)

\_\_\_\_\_

Has a doctor told you that you have cancer or a malignant tumor, not including skin cancer?

- ☐ Yes  
☐ No

Do you have a lung condition that limits your usual activities or makes you need oxygen at home?

- ☐ Yes  
☐ No

Has your doctor ever told you that you have congestive heart failure?

- ☐ Yes  
☐ No

Have you smoked cigarettes in the past week?

- ☐ Yes  
☐ No

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**Because of a health or memory problem:**

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	Yes	No
Do you have any difficulty with bathing or showering?	<input type="radio"/>	<input type="radio"/>
Do you have any difficulty with managing your money- such as paying your bills and keeping track of expenses?	<input type="radio"/>	<input type="radio"/>

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**Because of a health problem:**

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	Yes	No
Do you have any difficulty with walking several blocks?	<input type="radio"/>	<input type="radio"/>
Do you have any difficulty with pulling or pushing large objects like a living room chair?	<input type="radio"/>	<input type="radio"/>

  

	Yes	No
Had bodily pains in the last 1 or 2 weeks?	<input type="radio"/>	<input type="radio"/>
Had a hard time sleeping because of pain?	<input type="radio"/>	<input type="radio"/>
Not wanted to do things you usually like doing in the last 2 weeks?	<input type="radio"/>	<input type="radio"/>
Been feeling down or depressed in the past 2 weeks?	<input type="radio"/>	<input type="radio"/>
Fallen down in the last year?	<input type="radio"/>	<input type="radio"/>
Needed to go to the hospital if you did fall down?	<input type="radio"/>	<input type="radio"/>
Fractured your hip?	<input type="radio"/>	<input type="radio"/>
Leaked urine when you did not want to?	<input type="radio"/>	<input type="radio"/>

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**The next few questions have to do with your experiences of low blood sugar, also called low blood glucose or hypoglycemia. A person with low blood sugar may have symptoms such as sweating, weakness, anxiety, confusion, trembling, hunger or headache.**

Which of the following statements best describes you?

- ☐ I always have symptoms when my blood sugar is low
- ☐ I sometimes have symptoms when my blood sugar is low
- ☐ I don't have symptoms when my blood sugar is low
- ☐ I haven't had low blood sugar
- ☐ Don't know

In the past 4 weeks, about how many times have you had low blood sugar (symptoms of low blood sugar or blood sugar less than 70 mg/dl)?

- ☐ 8 or more times
- ☐ 4-7 times
- ☐ 1-3 times
- ☐ 0 or none
- ☐ Don't know

In the past 4 weeks, did your blood sugar become too low because of any of the following reasons? (check all that apply)

- ☐ Skipped a meal, did not eat enough or waited too long to eat
- ☐ Did more physical activity than usual
- ☐ Took insulin incorrectly (wrong timing, dose, or type)
- ☐ Took too many diabetes pills by mistake
- ☐ Started on new diabetes medications (pills or shots)
- ☐ Changed my dose of insulin or other diabetes medication
- ☐ Was sick or had an infection
- ☐ Drank too much alcohol
- ☐ Other
- ☐ Don't know

Other:

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In the past year, have you had low blood sugar that resulted in passing out or needing help from someone else? (For example, you were unable to treat yourself, were unconscious or needed glucagon or intravenous glucose).

- ☐ Yes
- ☐ No
- ☐ Don't know

If yes, how many times?

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Do you take medications for your diabetes?

- ☐ Yes
- ☐ No

In the past 12 months, did you take less medication than was prescribed because of its cost? For example, did you try to stretch out your medications, skip doses, take smaller doses, stop a medication, not fill a prescription, or not start a medication? Please answer yes only if the COST of the prescription was the main reason that you used less than what was prescribed.

- ☐ Yes
- ☐ No
- ☐ I don't take any medications
- ☐ Don't know

In the past 12 months, did you ever use less medication than prescribed for any of the following reasons? (check all that apply)

- ☐ I was unsure why a medication was prescribed
- ☐ It was hard to remember to take my medication as directed
- ☐ It was hard to fit my medications into my schedule
- ☐ It was too hard to get refills
- ☐ I was concerned about side effects or negative long-term health effects
- ☐ I dislike taking medications in general
- ☐ I try to manage my health with lifestyle changes instead (such as exercise or diet)
- ☐ Other
- ☐ None of the above- I took my medication as prescribed

Other:

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How much have you been bothered by side effects of your diabetes medication(s)?

- ☐ Not at all  
☐ A little  
☐ Somewhat  
☐ Quite a bit  
☐ Very much  
☐ Don't know

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**How much do you agree or disagree with each of the following statements about taking diabetes medications in the future?**

	Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree	Don't know
Would you be interested in taking less diabetes medications, even if your sugars will be higher?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am willing to take oral medication (pills, tablets) to help lower my sugars	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am willing to take injections to help lower my sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I want to be involved in making decisions about my diabetes goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowing how well my diabetes is controlled is important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Do you currently have a goal for your A1C (also called hemoglobin A1c or HbA1c)?

- ☐ Yes  
☐ No  
☐ Don't know

My goal is an A1C less than \_\_\_\_ (usually a number in the range of 5-14)

\_\_\_\_\_

What goals do you have for managing your diabetes?

\_\_\_\_\_

In addition to routine care provided by your primary care provider, would you be interested in any of the following to receive more help for managing your diabetes? (check all that apply)

- ☐ Phone calls  
☐ MyChart  
☐ Group diabetes education classes  
☐ One-on-one diabetes education classes  
☐ Other  
☐ None of the above

Other:

\_\_\_\_\_

	Never	Occasionally	Sometimes	Often	Always
How often do you have problems learning about your medical condition because of difficulty understanding written information?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How confident are you filling out medical forms by yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How often do you have someone help you read hospital material?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did someone help you complete this survey (for example, read the questions to you or write in responses)?

- ☐ Yes  
☐ No

What is the highest grade of school you completed or the highest degree you received?

- ☐ Junior HS or less  
☐ Some HS (no degree)  
☐ HS graduate, GED, or equivalent  
☐ Some college  
☐ Associate Degree  
☐ Technical, or Vocational program  
☐ Bachelor's Degree  
☐ Master's Degree or Doctoral Degree

Height in inches

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BMI

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Score\_sex

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Score\_cancer

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Score\_lung\_condition

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Score\_heart\_failure

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Score\_smoking

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Score\_bathing

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Score\_finances

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Score\_walking

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Score\_push\_or\_pull

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Score\_bmi

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Score\_age

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Total Score

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