Medical Expenditure Panel Survey

A Survey About Your Diabetes Care

The care of people with diabetes is an important concern of the Public Health Service. 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).

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.
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 2005, how many times did a doctor, nurse, or other health professional check your blood for glycosylated hemoglobin or "hemoglobin A-one-C"? (FILL IN NUMBER OF TIMES)
   Number of Times .................
   Did not have a blood test .......... ☐ 96
   Don't know............................ ☐ 98
   Never ................................... ☐ 00

3. During 2005, 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 2006 ......................... ☐ 1
   During 2005 ......................... ☐ 2
   During 2004 ......................... ☐ 3
   Before 2004 ......................... ☐ 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
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 shot?
    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?

__________________________________________________________________

__________________________________________________________________