

HUNT 1

Questionnaire 2c Diabetes

Page 1

You have stated that you have diabetes. One of the main goals of this study is to find ways to treat diabetes that, as much as is possible, avoid discomfort.

We ask therefore that those who suffer from or have suffered from diabetes answer these questions on diabetes to the best of their abilities.

You may have completed a similar form in the autumn of 1982. Nevertheless, it is very important that you complete this form as well.

All information will be treated in the strictest confidence.

Thank you !

When were you first diagnosed with diabetes?

(Write the year in the box) <year>

Under what circumstances were you diagnosed with diabetes?

I consulted a doctor because of symptoms

It was discovered without my having symptoms (examination for a medical certificate, company medical examination, examination for another complaint at a hospital or elsewhere)

What symptoms did you have around the time the diabetes was discovered?

(Place an X in more than one box if applicable)

None

Abnormal thirst

Excessive urination

Lethargy

Weight loss

Vaginal itching

Other symptoms

If OTHER SYMPTOMS, specify:

Has your mother, father, siblings or your children had diabetes? <yes, no>

If YES, do or did any of them take insulin injections? <yes, no>

TREATMENT

Do you take insulin injections? <yes, no>

If YES, do you inject insulin daily?

Injection once a day

Injection twice or more times a day

If you inject insulin, how much insulin, in total, do you take every day?

(Write the number of ml in the box - 1 "line" corresponds to 0.1ml) <ml>

If you inject insulin, what is the name of the insulin you use?

(Write the name written on the bottle, both names if you use two types)

Do you take tablets for your diabetes? <yes, no>

If you take tablets for your diabetes, write the name of the tablets below, the mg written on the bottle/packet and the number of tablets you take per day:

(If you take more than one type of tablet for your diabetes, write the names of both)

Write the name of the tablet here

mg pr. tabl.

no.pr.day

Write the name of the tablet here

mg pr. tabl.

no.pr.day

How many meals do you eat a day? <number>

Do you feel you know enough about the kinds of food you can eat? <yes, no>

If you were to say what you actually eat rather than what your doctor says you should eat, would you say that you:

(Only put an X in one box, the one that is most like what you actually do)

Eat more or less the same as those who do not suffer from diabetes

Eat what I like, but not sugar and sweets

Use approximately measured quantities of bread, potatoes, milk and fruit

Weigh/measure specific quantities of bread, potatoes, milk and fruit one or more days a week

Do you check the quantity of sugar in your urine at home?

(Answer YES if somebody helps you or does it for you.) <yes, no>

What is the name of the method you use to measure the sugar in your urine?

Write the name on the package here:

Do you check how much sugar you have in your blood (blood sugar level) at home?
(Answer YES if somebody helps you or does it for you.) <yes, no>

What is the name of the method you use to measure your blood sugar?

Write the name on the packet and the name of any instrument you use for measuring:

If you check the sugar content in you urine or blood yourself, how often do you do so?
(Answer how often also if somebody helps you or does it for you; place an X in the appropriate box.)

Every day

2 - 3 days of the week

Once a week

Every fortnight

Once a month

Less than once a month

Page 2

If the sugar level in your urine or blood is checked at home, do you take the measurement several times a day the days this is done? <yes, no>

If urine or blood samples are taken at home, do you take the results with you to your doctor when you go for medical examinations?

(Place an X in the appropriate box)

Never

Sometimes

Usually

Always

Do you see a doctor regularly for your diabetes? <yes, no>

If YES, how much time passed between the last two times you visited your doctor for your diabetes examination?

Number of months (write in the box) _____

What type of doctor do you see regularly for your diabetes?

(Place an X in only one box)

Ordinary doctor (local medical officer, general practitioner, company doctor, etc.)

Hospital doctor (outpatient department at hospital)

I live in a nursing home or other institution and am examined there

Other

If OTHER, write what type of doctor on the line above.

OTHER ILLNESSES

Do you regularly take medicine for anything other than diabetes? <yes, no>

If YES, write the name of these medicines

(Write the name that appears on the bottle or packet. Include all medicines taken on a regular basis. Place an X behind the name of any medicine that you took before you were diagnosed with diabetes.)

Do you believe that people are more vulnerable to certain illnesses if their diabetes is not properly controlled? <yes, no>

If YES, write the names of 3 such illnesses

(You need not have suffered from these illnesses yourself)

Have you suffered from any lasting (chronic) complaints since having diabetes?

(Write illnesses/complaints on the lines below)

INSTRUCTION - SUPPORT

Are you a member of the Norwegian Diabetes Association? <yes, no>

Have you ever attended courses or meetings on diabetes? <yes, no>

Are you receiving basic benefits for your diabetes from social security? <yes, no>

Have you applied for and been granted a tax allowance because you have diabetes? <yes, no>

HOW DO YOU FEEL?

Do you find having diabetes difficult?

(Place an X in the appropriate box)

Yes, I feel it is a problem everyday

Yes, I think about it a lot

Yes, sometimes

No, rarely

No, I hardly ever think about it

I feel I am the same as people who do not have diabetes

If you find it difficult having diabetes, what do you like least?

(Write your opinion on the line below)

Do you tell others that you have diabetes?

(Place an X in the appropriate box)

Yes, always if I think they should know

Yes, but only if they ask

No, prefer not to

It worries me that people might find out

Has your blood sugar level ever been too low (“hypoglycaemia”, “insulin shock”)?

<yes, no>

If YES, how many times has this happened in the last week?

(Write the number of times in the box) _____

How many times have you been hospitalized during the last 5 years?

(Write the number of times in the box) _____

If you have been hospitalized during the last 5 years, state why?

(Write on the lines below)
