Apollo Sugar Clinics
CENTRE OF EXCELLENCE FOR DIABETES AND ENDOCRINOLOGY

First Visit Questionnaire:

1. Are you aware of which type of diabetes you have?
   a. Yes b No
2. Is there anyone in the family with diabetes?
   a. Yes b. No
3. Do you know about the diabetes, what happens and how it occurs?
   a. Yes b. No c. Not much
4. Do you know or heard about the complications and factors that are associated with diabetes?
   a. Yes b. No d. Very little information

5. Do you have any past history of
   a. Hypertension b. Abnormal lipid profile . c. Cardiovascular/Heart disease
   d. Kidney e. Neuropathy/Foot problems f. Retinopathy/Eye problems
   g. Smoking
6. Are you initiated with insulin treatment? If yes, have you received enough information on how to take with insulin?
   a. Yes b. No c. Not much information
7. Do you know about hypoglycemia?
   a. Yes b. No
8. Would you like to know about how to manage diabetes with diet, exercise, treatment regimen and self-management?

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Follow Up Visit Questionnaire:

1. How are you coping with self-care and self-management of diabetes
    a. Good b. Better c. bad
2. Are you informed about how to manage with your diet
    a. Yes b. No
3. Would you like to receive educational inputs dietetics, exercise, insulin regimen, treatment adherence to improve your understanding about the condition and self-management?
    a. Yes b. No c. don't know
4. Are you still smoking? If yes, what help do you need to stop smoking
5. Were you hospitalized for any of the below complications
    a. Hypoglycemia b. diabetic ketoacidosis c. hyperglycemic state?
6. In the past have you experienced symptoms associated with the any of the below complications
    a. Cardiovascular b. Renal c. Eye d. Nerve e. Foot
7. How are you coping with and complying with diabetes medication regimen?
    a. Tight adherence to medication pattern
    b. Monitoring the dose adjustments as when required
8. Are you on Insulin? If yes, do you face any problem with injection or insulin?
    a. Yes b. No c. not really
9. Do you have any problem with timing of insulin or oral medications?
    a. Yes b. No
10. Do you miss your medication regularly? Yes/No. If yes, how frequently?
    a. Weekly once b. Monthly once c. Atleast once in a day
11. Do you monitor your blood glucose regularly using glucose monitoring device?
    a. Yes b. No
12. Do you maintain the record of your glucose readings?
    a. Yes b. No