

EPIDEMIOLOGY OF DIABETES INTERVENTION AND COMPLICATIONS
Health Care Delivery Questionnaire

This questionnaire is to be completed by the study participant at each annual visit. Many of the following questions request information regarding the previous 6 months. However, you should read the question carefully to be sure that you are using the requested time frame. Do not count today's visit when answering the questions. A copy of this form should be retained in the clinic file and the original should be sent to the Data Coordinating Center in the monthly mailing.

A. IDENTIFYING INFORMATION

1. Clinic Number: _____
2. Patient ID Number: _____
3. Patient's Initials: _____
4. Date Form Completed: _____
Month Day Year
5. EDIC Year _____

B. HEALTH CARE DELIVERY

1. During the past 6 months, were you a patient in a nursing home? No Yes
(1) (2)
If no, go to Question B.2
 - a. How many nights all together during the past 6 months did you stay in the nursing home?
(Enter total number of nights) _____
2. During the past 6 months, did you stay in a hospital overnight? No Yes
(1) (2)
If no, go to Question B.3.
 - a. How many times in the past 6 months did you stay in a hospital?
(Enter total number of times) _____
 - b. How many nights all together during the past 6 months did you stay in a hospital? _____

- c. Please list the names of all the hospitals in which you have stayed overnight or longer during the past 6 months (use back of this page if necessary):

Hospital Name	City
_____	_____
_____	_____
_____	_____

- d. Were any of the times in the past 6 months that you stayed in a hospital overnight not provided or paid for, at least in part, by health insurance? No Yes
(1) (2)
If no, go to Question B.3.
 - i) During the past 6 months, how many times was your stay in the hospital not provided or paid for by your health insurance?
(Enter total number of times) _____
 - ii) During the past 6 months, how many total nights in the hospital were not provided or paid for by your health insurance?
(Enter total number of nights) _____

3. Please indicate which of the following types of doctors you have ever visited, and the date of your MOST RECENT VISIT.

	Have you ever seen this type of doctor?		Date of Most Recent Visit (Month/Year)
	No	Yes	
	(1)	(2)	
a. An <u>ENDOCRINOLOGIST</u> M.D. or diabetes specialist	(1)	(2)	___ ___/___ ___
b. An <u>OPHTHALMOLOGIST</u> M.D. (eye specialist) for an eye check-up for diabetes.	(1)	(2)	___ ___/___ ___
c. An <u>OPHTHALMOLOGIST</u> M.D. (eye specialist) for some other reason (glasses, cataracts)	(1)	(2)	___ ___/___ ___
d. An <u>OPTOMETRIST</u> (Not an M.D.)	(1)	(2)	___ ___/___ ___
e. A <u>CARDIOLOGIST</u> (heart specialist) for heart problems	(1)	(2)	___ ___/___ ___

	Have you ever seen this type of doctor?		Date of Most Recent Visit (Month/Year)
	No	Yes	
	(1)	(2)	
f. A <u>PODIATRIST</u> (foot specialist) for foot problems	(1)	(2)	___ ___/___ ___
g. A <u>NEPHROLOGIST</u> (kidney specialist) for kidney problems	(1)	(2)	___ ___/___ ___
h. The doctor who <u>takes care of your diabetes</u> (may be an endocrinologist or another doctor such as a family practitioner, GP or internist)	(1)	(2)	___ ___/___ ___
i. Some other type of doctor for (please specify): _____	(1)	(2)	___ ___/___ ___

4. How many visits PER YEAR does the doctor who treats your diabetes recommend that you make to:
(Circle one for each item)

	More than 2 visits per year	About two visits per year	About one visit per year	Less than one visit per year	Does Not Recommend
a. Eye doctor (ophthalmologist/optometrist)	1	2	3	4	5
b. Foot doctor (podiatrist)	1	2	3	4	5
c. Health education specialist (such as a teaching nurse)	1	2	3	4	5
d. Dietitian or nutritionist	1	2	3	4	5

5. During the PAST 2 WEEKS, how many total visits to doctors did you make? (Do not count today)

(Enter total number of visits) ___ ___

6. During the PAST 6 MONTHS, have you seen any of the following health care providers?
 (Do not include visits by providers while you were in a hospital overnight.)

	No Yes		How many visits did you make? (Enter Number of Visits)	HOW MANY OF THESE VISITS WERE AT LEAST PARTLY PAID FOR BY:		
				Your health insurance (Enter Number of Visits)	Other insurance (Enter Number of Visits)	Completely paid for by yourself (Enter Number of Visits)
a. Doctor who takes care of your diabetes (May include a diabetes specialist, Internist, Family Practitioner)	(1)	(2)	___	___	___	___
b. Endocrinologist or diabetes specialist	(1)	(2)	___	___	___	___
c. Ophthalmologist M.D. (eye specialist)	(1)	(2)	___	___	___	___
d. Optometrist (not an M.D.)	(1)	(2)	___	___	___	___
e. Cardiologist (heart specialist)	(1)	(2)	___	___	___	___
f. Nephrologist (kidney specialist)	(1)	(2)	___	___	___	___
g. Surgeon	(1)	(2)	___	___	___	___
h. Urologist (treats bladder and kidney problems, impotence)	(1)	(2)	___	___	___	___
i. Psychiatrist or Psychologist	(1)	(2)	___	___	___	___
j. General Internist or Family Doctor (other than the one who takes care of your diabetes)	(1)	(2)	___	___	___	___
k. Podiatrist (foot specialist)	(1)	(2)	___	___	___	___
l. Nurse Practitioner or Physician Assistant	(1)	(2)	___	___	___	___
m. Dietitian or Nutritionist	(1)	(2)	___	___	___	___
n. Other provider (please specify): _____	(1)	(2)	___	___	___	___

7. During the PAST 6 MONTHS, how many total visits to all health care providers (doctors, nurses, dietitians psychologists) did you make? (Enter total number of visits)
8. During the PAST 6 MONTHS have you had any of the following laboratory tests, x-rays, or procedures? (Do not count tests that were done while you were in a hospital overnight).

HOW MANY OF THESE VISITS WERE AT LEAST PARTLY PAID FOR BY:

	How many times? (Enter Number)		Your health insurance (Enter Number of visits)	Other insurance (Enter Number of visits)	Completely paid for yourself (Enter Number of visits)
	No	Yes			
a. Blood glucose (done by doctor's office, laboratory or clinic)	(1)	(2)	_____	_____	_____
b. Other blood tests	(1)	(2)	_____	_____	_____
c. Electrocardiogram (ECG)	(1)	(2)	_____	_____	_____
d. Echocardiogram	(1)	(2)	_____	_____	_____
e. Stress test (treadmill test)	(1)	(2)	_____	_____	_____
f. Chest x-ray	(1)	(2)	_____	_____	_____
g. Urine tests	(1)	(2)	_____	_____	_____
h. Other major tests, such as specialized x-rays (please specify):					
_____	(1)	(2)	_____	_____	_____
_____	(1)	(2)	_____	_____	_____
_____	(1)	(2)	_____	_____	_____
_____	(1)	(2)	_____	_____	_____
_____	(1)	(2)	_____	_____	_____

D. HEALTH CARE SCHEDULING

- | | | |
|---|------|------|
| 1. In the past year, did you have any health problem(s) or condition(s) that you would have liked to have seen a doctor or other medical person about, but you did not? | No | Yes |
| | (1) | (2) |

If NO, go to Question 2.

If YES, indicate below the reasons that explain why you did not see a doctor for this problem or condition (check all that apply):

<u>Reason</u>	<u>Condition</u>			
	General Diabetic Care	Eye Care	Foot Care	Other _____
a. Did not think that the condition was serious	(1)	(1)	(1)	(1)
b. Thought the visit would cost too much	(1)	(1)	(1)	(1)
c. Did not have time	(1)	(1)	(1)	(1)
d. Could not get an appointment, office hours were inconvenient	(1)	(1)	(1)	(1)
e. Did not have a way to get to the doctor	(1)	(1)	(1)	(1)
f. Did not have anyone to care for the children	(1)	(1)	(1)	(1)
g. Felt the doctor could not do much for the condition	(1)	(1)	(1)	(1)
h. Were afraid of finding out what was wrong	(1)	(1)	(1)	(1)
i. Other, specify: _____	(1)	(1)	(1)	(1)

2. In the last year, do you feel that you delayed seeing a doctor or other medical person longer than you should have? No Yes
(1) (2)

If YES, what was the principal reason why?

- a. Could not get an appointment, office hours were inconvenient. (1)
- b. The costs of medical care were too high. (2)

- c. You did not have time to see a doctor. (3)
- d. You did not have a way to get to the doctor. (4)
- e. You thought the problem would go away. (5)
- f. You did not have anyone to care for the children. (6)
- g. Other, specify: _____ (7)

Patient ID _____

E. SETTING OF USUAL HEALTH CARE

1. Which medical setting (below) best describes where you most often receive medical care?

- a. A doctor's private office (1)
- b. A hospital outpatient diabetes clinic (2)
- c. A hospital emergency room (3)
- d. A health center (4)
- e. A company clinic (5)
- f. Other, specify: _____ (6)

2. Who is currently giving you your diabetes care?

- a. EDIC staff (1)
- b. Another physician at EDIC site (2)
- c. Another physician at separate site (3)