

Entered: __/__/20__ mm dd yy	Initials: _____	Verified: __/__/20__ mm dd yy	Initials: _____
Patient ID _____ - _____ - _____ ID			Visit: 1
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MAB Form –Version 02/28/2009 FORMV

Form Completion Date __/__/20__ **MABDAT**
mm dd yy

The next set of questions ask about various medical conditions that you may or may not have had.

1. Have you **ever** had surgery on... (check “no” or “yes” to each):

	No	Yes
1.1 your back, such as disc surgery, laminectomy, or fusion surgery? SBACK	<input type="checkbox"/>	<input type="checkbox"/>
1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery? SHIP	<input type="checkbox"/>	<input type="checkbox"/>
1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery? SKNEE	<input type="checkbox"/>	<input type="checkbox"/>
1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery? SANKLE	<input type="checkbox"/>	<input type="checkbox"/>

2. In the **past 4 weeks**, have you suffered from back or leg pain, such as pain that radiates or shoots down the back of the leg to the knee or foot? **BACKLEG** ☐ 0. No ☐ 1. Yes

If yes, (answer the questions in this box):

2.1 In the **past 4 weeks**, how bothersome have each of the following symptoms been?

	Not at all bothersome	Slightly bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
a. Back pain BPAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Leg pain LPAIN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.2 In the **past 4 weeks**, how much did pain interfere with your normal work, including both work outside the home and house work? **WPAIN**

Not at all	A little bit	Moderately	Quite a bit	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.3 If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? **NOWON**

Very dissatisfied	Dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Satisfied	Very satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2.4 In the **past 4 weeks**, about how many days did you cut down on the things you usually do for more than half the day because of back pain or leg pain? **CUTDOWN**

_____ (Number of days)

2.5 In the **past 4 weeks**, how many days did low back pain or leg pain, keep you from going to work or school? **STOPDO**

_____ (Number of days) (write "n/a" if you did not go to work or school in the past 4 weeks)

The following was removed due to copyright permissions:

Western Ontario and McMaster's University (WOMAC) Osteoarthritis Index

Nicholas Bellamy, University of Queensland

4. Can you walk, assisted or unassisted? **CANWALK**

☐ 0. No ☐ 1. Yes

If yes,

4.1 Check the description below that best characterizes your walking ability: **FS**

- ☐ 1. I can walk 200 ft (length of grocery store aisle) unassisted.
☐ 2. I can walk 200 ft with an assistive device (such as a cane or walker).
☐ 3. I cannot walk 200 ft with an assistive device.

4.2 Do you **currently** use any of the following to aid with walking (check "no" or "yes" to each, if yes specify how often):

	No	Yes	If yes, how often?	Rarely (less than once per week)	Sometimes (about 3 times per week)	Often (almost every day)	Always (I can't walk without it)
a. A wheelchair WCHAIR	<input type="checkbox"/>	<input type="checkbox"/>	→ WCHAIRO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. A walker WALKER	<input type="checkbox"/>	<input type="checkbox"/>	→ WALKERO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. A cane CANE	<input type="checkbox"/>	<input type="checkbox"/>	→ CANEO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Have you **ever** had surgery for acid reflux, heartburn or a hiatal hernia? **SURGACID**

☐ 0. No ☐ 1. Yes

6. Have you **ever** had surgery to remove your gallbladder? **SURGGALL**

☐ 0. No ☐ 1. Yes

If no,

6.1 In the **past 3 months**, have you had upper abdominal pain shortly after eating food? **ABDP**

☐ 0. No ☐ 1. Yes

7. Have you **ever** been told by a doctor or other health care professional that you had a blood clot of the **lung(s)** also known as a **pulmonary embolism (PE)** requiring blood thinners? **CLOTEPE**

☐ 0. No ☐ 1. Yes

8. Have you **ever** been told by a doctor or other health care professional that you had a blood clot of the **leg(s)** also known as **deep phlebitis, deep vein thrombosis or DVT** requiring blood thinners? **CLOTDTV**

☐ 0. No ☐ 1. Yes

9. Have you **ever** been told by a doctor or other health professional that you had a myocardial infarction or heart attack? **MI**

☐ 0. No ☐ 1. Yes

If yes,

9.1 Was it within the past year? **MIYEAR**

☐ 0. No ☐ 1. Yes

☐ 0. No ☐ 1. Yes

10. Are you **currently** using supplemental oxygen such as an oxygen tank to help you breathe?

If yes,

SUPOXY

10 How often do you use supplemental oxygen such as an oxygen tank to help you breathe? **SUPOXYO**

Rarely (less than once per week)	Sometimes (about 3 times per week)	Often (almost every day)	Always (I can't breathe without it)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. Have you **ever** been told by a doctor or other health care professional that you have asthma?

☐ 0. No ☐ 1. Yes

ASTHMA

The following was removed due to copyright permissions:

Asthma Control test

American Lung Association <http://www.asthmacontrol.com/>

12. Have you ever had a kidney stone? **STONE**

☐ 0. No ☐ 1. Yes

13. Have you experienced low blood sugar in the **past 3 months**? **LOWBLOOD**

☐ -3. Don't know → Go to question 14 (next page)

☐ 0. No → Go to question 14 (next page)

☐ 1. Yes→

a. How many times during the last **7 days** do you think that you had low blood sugar? **SUGLOW** (# of times)

b. In general, do your low blood sugars typically happen (check one): **SUGHAP**

- ☐ 1. 4 hours or less after a meal or snack
☐ 2. More than 4 hours after a meal or snack
☐ 3. There is no typical relationship to meals or snacks

c. Have you generally had any of the following symptoms during your episode of low blood sugar (check no or yes for each)?

No Yes

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Hunger SUGHUNG |
| <input type="checkbox"/> | <input type="checkbox"/> | b. Anxiousness SUGANXI |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Sweating SUGSWEA |
| <input type="checkbox"/> | <input type="checkbox"/> | d. Heart pounding SUGHEAR |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Shakiness SUGSHAK |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Dizziness SUGDIZZ |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Trouble concentrating SUGCONC |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Trouble remembering words SUGREME |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Blackouts SUGBLAC |

d. In the past **3-months**, how many times was your low blood sugar so severe that you needed someone to help you (including a visit to the ER or hospitalization)? **SUGNOER** (# of times)

e. Was your blood sugar checked during the most severe episode of low blood sugar during the **past 3 months**? **SUGCHK**

- ☐ 0. No
☐ 1. Yes → What was the glucose value? (mg/dL) **GLUCVAL**

14. Do you **currently** have diabetes? **DM** ☐ 0. No ☐ 1. Yes

If yes,

14.1 How long have you had diabetes? _____ (years) **DMHAVE**14.2 Are you **currently** taking medications for diabetes? (check "no" or "yes" for each)

	No	Yes	
a. Oral diabetes medication	DMORAL	If yes, →	14.2.1 How many years have you been taking oral diabetes medication? ORALYR (yrs)
b. Insulin	DMINSU	If yes, →	14.2.2 How many total units of insulin do you currently inject each day? INSDOSE 14.2.3 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes? INSYEAR
c. Non-insulin injectable (e.g. Byetta (exenatide) or Symlin (pramlintide))	DMNONI	If yes, →	14.2.4 How many total units of non-insulin do you currently inject each day? DMNONID 14.2.5 How many total years have you been taking injections (insulin and/or non-insulin) for diabetes? DMNONIY

14.3 Have you **ever** required hospitalization for treatment of a diabetes complication? ☐ 0. No ☐ 1. Yes**DMCOMP**

If yes,

14.3.1 During your hospitalization, were you treated for any of the following due to diabetes:

			<i>Did this occur within the last 12 months?</i>	
No	Yes		No	Yes
DMHIG	Very high blood sugar or coma	→	DMHIG12	
DMKETO	Ketoacidosis	If	DMKETO12	
DMCELL	Severe skin infection (cellulitis)	Yes	DMCELL12	
DMFLO	Low blood flow to the toes, foot, or leg (claudication)	→	DMFLO12	
DMAMP	Amputation of the toes, foot, or leg	→	DMAMP12	
DMGAS	Nausea and vomiting due to gastroparesis	If	DMGAS12	
DMKID	Kidney failure or other kidney complication	If	DMKID12	
DMOT	Other (Specify: DMOTS)	Yes	DMOT12	
		→		

15. In the last 12 months, have you been treated for a nutritional deficiency? **NUT** ☐ 0. No ☐ 1. Yes

If yes, which nutrient(s)?

No	Yes
NUTVA	Vitamin A
NUTVB12	Vitamin B12
NUTVD	Vitamin D
NUTFOL	Folate
NUTTHIA	Thiamin
NUTIRON	Iron
NUTCAL	Calcium
NUTLTH1	Other 1 (Specify: NUTOTH1S)
NUTOTH2	Other 2 (Specify: NUTOTH2S)
NUTOTH3	Other 3 (Specify: NUTOTH3S)

16. In the last 12 months, have you experienced a fracture or broken bone? ☐ 0. No ☐ 1. Yes
If yes, **NUTBROK**

16.1 Was there a definite injury involved? ☐ 0. No ☐ 1. Yes **NUTBROKI**

17. In the last 12 months, have you noticed a definite change in your memory? **NUTMEM** ☐ 0. No ☐ 1. Yes

17.1 Has your memory gotten better or worse? **NUTMEMS** ☐ 0. Worse ☐ 1. Better

18. In the last 12 months, have you experienced unusual hair loss to the point of being noticed by others or requiring a wig? ☐ 0. No ☐ 1. Yes
NUTHAIR

19. In the last 12 months, have you experienced any changes or abn of your skin? ☐ 0. No ☐ 1. Yes
NUTSKIN

20. These next set of questions ask about the feeling in your legs and feet. Check “No” or “Yes” based on how you usually feel?

	No	Yes
20.1 Are your legs and/or feet numb? LEGNUMB	<input type="checkbox"/>	<input type="checkbox"/>
20.2 Do you ever have any burning pain in your legs and/or feet? LEGPAIN	<input type="checkbox"/>	<input type="checkbox"/>
20.3 Are your feet too sensitive to touch? FEETSENS	<input type="checkbox"/>	<input type="checkbox"/>
20.4 Do you get muscle cramps in your legs and/or feet? LEGCRAMP	<input type="checkbox"/>	<input type="checkbox"/>
20.5 Do you ever have any prickling feelings in your legs or feet? LEGPRICK	<input type="checkbox"/>	<input type="checkbox"/>
20.6 Does it hurt when the bed covers touch your skin? BEDCOVER	<input type="checkbox"/>	<input type="checkbox"/>
20.7 When get into the tub or shower, able to tell hot water from the cold water? HOTCOLD	<input type="checkbox"/>	<input type="checkbox"/>
20.8 Have you ever had an open sore on your foot? OPENSORE	<input type="checkbox"/>	<input type="checkbox"/>
20.9 Has your doctor ever told you that you have diabetic neuropathy? DNEURO	<input type="checkbox"/>	<input type="checkbox"/>
20.10 Do you feel weak all over most of the time? WEAKALL	<input type="checkbox"/>	<input type="checkbox"/>
20.11 Are your symptoms worse at night? SXNIGHT	<input type="checkbox"/>	<input type="checkbox"/>

Patient ID

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20.12 Do your legs hurt when you walk? LEGWALK	<input type="checkbox"/>	<input type="checkbox"/>
20.13 Are you able to sense your feet when you walk? FEETWALK	<input type="checkbox"/>	<input type="checkbox"/>
20.14 Is the skin on your feet so dry that it cracks open? FEETDRY	<input type="checkbox"/>	<input type="checkbox"/>
20.15 Have you ever had an amputation? AMPUT	<input type="checkbox"/>	<input type="checkbox"/>

Michigan Diabetes Research and Training Center

http://diabetesresearch.med.umich.edu/Tools_SurveyInstruments.php