Entered: _ _ / _ _ / 20_ _ Initials: _____ Verified: _ _ / _ _ /20 _ _ Initials: _____
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Patient ID __ __ __ - __ __ __ __ - __ __ **ID** **VISIT Visit:____**

For office use only.

MAF – Version: 09/01/2010 FORMV

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

1. In the **past 12 months**, have you had surgery on… *(check "no" or "yes" to each)*

	No	Yes
1.1 your back, such as disc surgery, laminectomy, or fusion surgery. **SBACK_F**	☐	☐
1.2 your hip(s), such as joint replacement, reconstructive or arthroscopic surgery. **SHIP_F**	☐	☐
1.3 your knee(s), such as joint replacement, reconstructive or arthroscopic surgery. **SKNEE_F**	☐	☐
1.4 your ankle(s), such as joint replacement, reconstructive or arthroscopic surgery. **SANKLE_F**	☐	☐

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**	☐	☐	☐	☐	☐
b. Leg pain **LPAIN**	☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐

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
☐	☐	☐	☐	☐	☐	☐

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. 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 devise (such as a cane or walker).
   - ☐ 3. I cannot walk 200 ft with an assistive device.

5. 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**		→		**WCHAIRO**		
b. A walker	**WALKER**		→		**WALKERO**		
c. A cane	**CANE**		→		**CANEO**		
d. A motorized assistive devise (e.g., scooter)	**MOTORD**		→		**MOTORDO**		
e. Other Specify: _ **OTHRAIDS**_	**OTHRAID**		→		**OTHRAIDO**		

6. In the **past 12 months,** have you had surgery for acid reflux, heartburn or a hiatal hernia? **SACID_F** ☐ 0. No ☐ 1. Yes

7. In the **past 12 months,** have you had surgery to remove your gallbladder? **SGALL_F** ☐ 0. No ☐ 1. Yes

If no,

7.1 In the **past 3 months**, have you had upper abdominal pain shortly after eating food? **ABDP** ☐ 0. No ☐ 1. Yes

8. In the **past 12 months**, have you been told by a doctor or other health care professional that you had a blood clot of the **lung(s) also know as a pulmonary embolism (PE)** requiring blood thinners? **CLOTPE_F** ☐ 0. No ☐ 1. Yes

9. In the **past 12 months,** have you 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? **DVT_F** ☐ 0. No ☐ 1. Yes

10. In the **past 12 months**, have you been told by a doctor or other health professional that you had a myocardial infarction or heart attack? **MIYEAR** ☐ 0. No ☐ 1. Yes

11 Are you **currently** using supplemental oxygen such as an oxygen tank to help you breath? **SUPOXY** ☐ 0. No ☐ 1. Yes

If yes,

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

Rarely *(less than once per week)*	**Sometimes** *(about 3 times per week)*	**Often** *(almost every day)*	**Always** *(I can't breath without it)*
☐	☐	☐	☐

12. In the **past 12 months**, have you been told by a doctor or other health care professional that you that you have asthma? **ASTHMA_F** ☐ 0. No ☐ 1. Yes

If yes,

The following was removed due to copyright permissions:
Asthma Control test
American Lung Association http://www.asthmacontrol.com/

13. In the **past 12 months,** have you had a kidney stone? ☐ 0. No ☐ 1. Yes
STONE_F

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

☐ -3. Don't know →
☐ 0. No →
☐ 1. Yes ↓

14.1. Have you experienced low blood sugar in the **past 12 months?**
☐ -3. Don't know → *Go to question 15(next page)*
☐ 0. No → *Go to question 15(next page)*
☐ 1. Yes → **SUG12**

If yes, **SUG12SEV**

14.1.1 Was your blood sugar checked during the most severe episode of low blood sugar during the **past 12 months?**
☐ 0. No
☐ 1. Yes→ What was the glucose value? __ __ __ (mg/dl)
SUG12GLU

Go to question 15 (next page)

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

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	
☐	☐	a. Hunger **SUGHUNG**
☐	☐	b. Anxiousness **SUGANXI**
☐	☐	c. Sweating **SUGSWEA**
☐	☐	d. Heart pounding **SUGHEAR**
☐	☐	e. Shakiness **SUGSHAK**
☐	☐	f. Dizziness **SUGDIZZ**
☐	☐	g. Trouble concentrating **SUGCONC**
☐	☐	h. Trouble remembering words **SUGREME**
☐	☐	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**

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

If yes,

15.1 Are you **currently** taking medications for diabetes? (check "no" or "yes" for each)

	No Yes		
a. Oral diabetes medication	**DMORAL**		
b. Insulin	**DMINSU**	If yes, →	14.1.1 How many total units of insulin do you currently inject each day? **INSDOSE**
c. Non-insulin injectable (*e.g. Byetta (exenatide) or Symlin (pramlintide)*)	**DMNONI**	If yes, →	14.1.2 How many total units of non-insulin do you currently inject each day? **DMNONID**

15.2 In past 12 months, have you required hospitalization for treatment of a diabetes complication?
☐ 0. No ☐ 1. Yes **DMCOMP_F**

If yes,

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

No Yes	
DMHIG_F	Very high blood sugar or coma
DMKETO_F	Ketoacidosis
DMCELL_F	Severe skin infection (cellulitis)
DMFLO_F	Low blood flow to the toes, foot, or leg (claudication)
DMAMP_F	Amputation of the toes, foot, or leg
DMGAS_F	Nausea and vomiting due to gastroparesis
DMKID_F	Kidney failure or other kidney complication
DMOT_F	Other (Specify: ____**DMOTS_F** _____)

16. **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	
NUTMV		Multi-Vitamin
NUTVA		Vitamin A
NUTVB12		Vitamin B12
NUTVD		Vitamin D
NUTTHIA		Thiamin (Vitamin B1)
NUTPOT		Potassium
NUTMAG		Magnesium
NUTFOL		Folate (Folic Acid)
NUTIRON		Iron (Ferrous sulfate)
NUTCAL		Calcium
NUTOTH1		Other 1 (Specify: **NUTOTH1S**)
NUTOTH2		Other 2 (Specify: **NUTOTH2S**)
NUTOTH3		Other 3 (Specify: **NUTOTH3S**)

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

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

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

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

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

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

21. 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
21.1 Are your legs and/or feet numb? **LEGNUMB**	☐	☐
21.2 Do you ever have any burning pain in your legs and/or feet? **LEGPAIN**	☐	☐
21.3 Are your feet too sensitive to touch? **FEETSENS**	☐	☐
21.4 Do you get muscle cramps in your legs and/or feet? **LEGCRAMP**	☐	☐
21.5 Do you ever have any prickling feelings in your legs or feet? **LEGPRICK**	☐	☐
21.6 Does it hurt when the bed covers touch your skin? **BEDCOVER**	☐	☐
21.7 When you get into the tub or shower, are you able to tell hot water from the cold water? **HOTCOLD**	☐	☐
21.8 Have you ever had an open sore on your foot? **OPENSORE**	☐	☐
21.9 Has your doctor ever told you that you have diabetic neuropathy? **DNEURO**	☐	☐
21.10 Do you feel weak all over most of the time? **WEAKALL**	☐	☐
21.11 Are your symptoms worse at night? **SXNIGHT**	☐	☐
21.12 Do your legs hurt when you walk? **LEGWALK**	☐	☐
21.13 Are you able to sense your feet when you walk? **FEETWALK**	☐	☐
21.14 Is the skin on your feet so dry that it cracks open? **FEETDRY**	☐	☐
21.15 Have you ever had an amputation? **AMPUT**	☐	☐

Michigan Diabetes Research and Training Center
http://diabetesresearch.med.umich.edu/Tools_SurveyInstruments.php