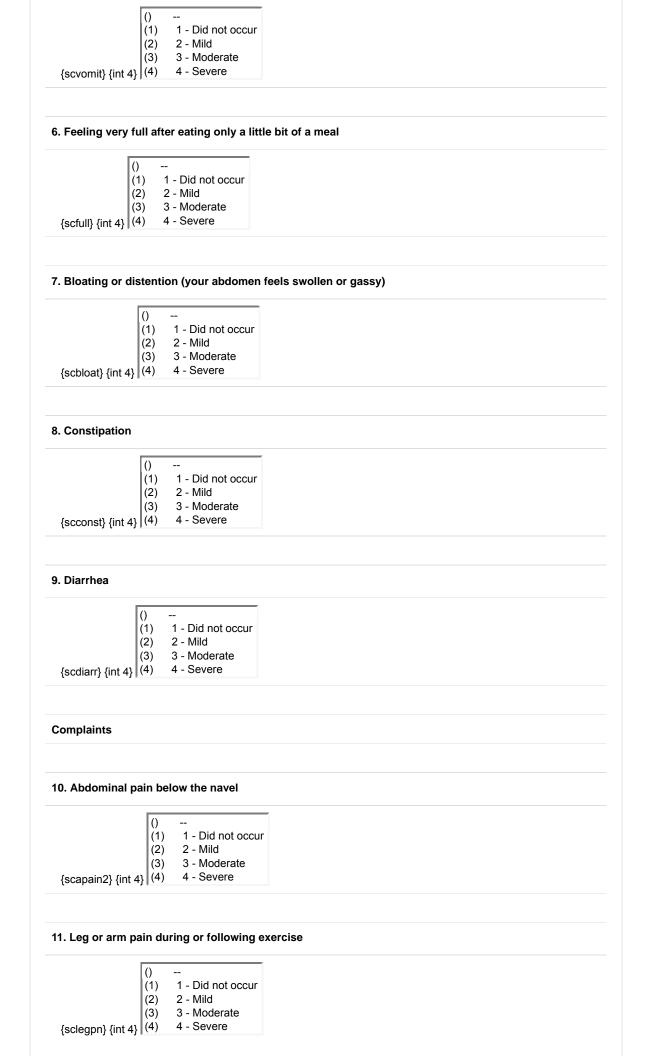
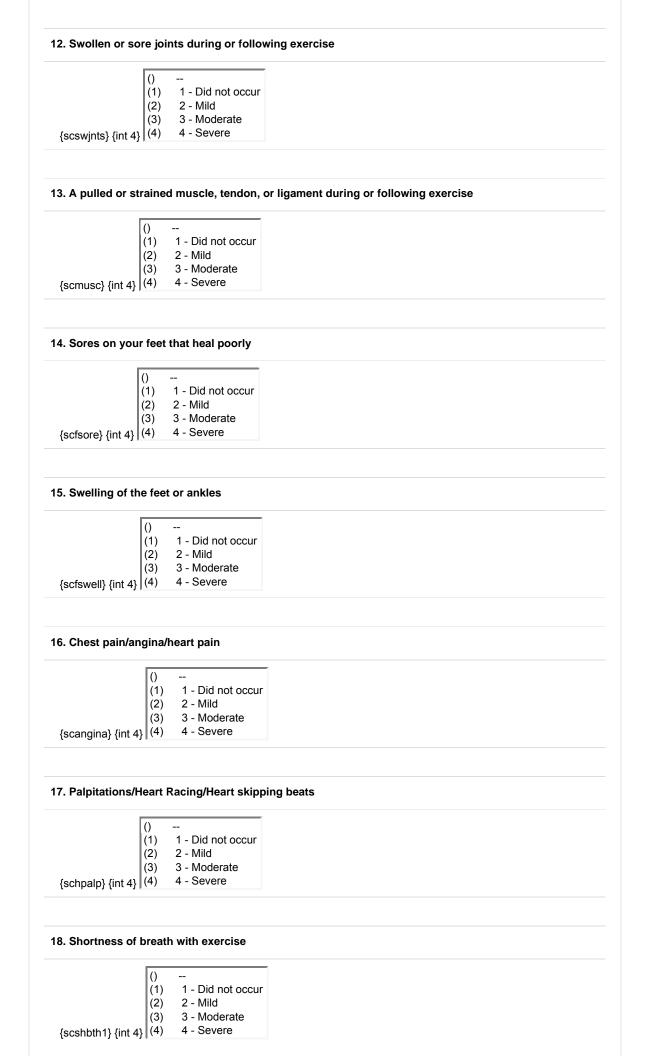
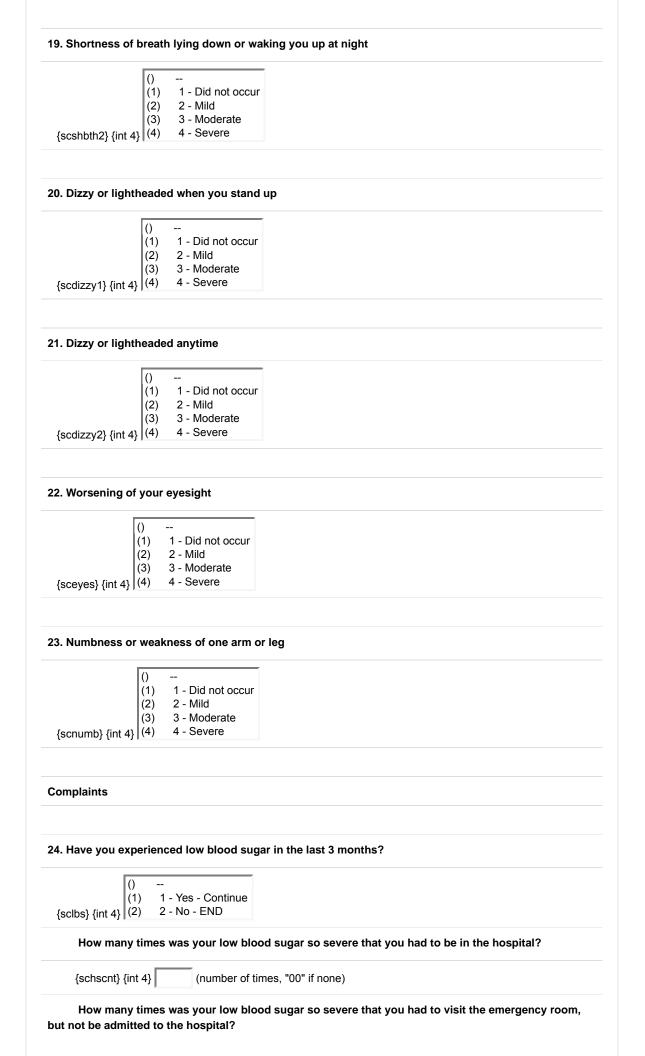
	M۱	/ Health -	Part B:	A. Com	plaints
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PID: Acrostic:	
Acrostic:	
Visit:	
Date Form Completed: mn	
	T/dd/yyyy
() (1) (2) (3) (4) (5) (6)) Mailed) Telephone) Interviewer-administered) Home
Administered by: STAFF II	
Language: (1) Ei	nglish panish avajo
A. Complaints	
1. Heartburn (burning a	sensation in chest or upper abdomen)
() (1) (2) (3) (4)	 1 - Did not occur 2 - Mild 3 - Moderate 4 - Severe
2. Regurgitation (the in	nvoluntary movement of liquids and foods from the stomach up into the throat)
() (1) (2) (3) (4) (4)	 1 - Did not occur 2 - Mild 3 - Moderate 4 - Severe
3. Nausea (feeling sick	to your stomach as if you were going to throw up or vomit)
3. Nausea (feeling sick	to your stomach as if you were going to throw up or vomit)
3. Nausea (feeling sick () (1) (2) (3) {scnausea} {int 4}	 1 - Did not occur 2 - Mild 3 - Moderate
() (1) (2) (3)	 1 - Did not occur 2 - Mild 3 - Moderate
() (1) (2) (3)	 1 - Did not occur 2 - Mild 3 - Moderate
() (1) (2) (3)	 1 - Did not occur 2 - Mild 3 - Moderate 4 - Severe
() (1) (2) (3) {scnausea} {int 4} (4) 4. Abdominal pain abo	 1 - Did not occur 2 - Mild 3 - Moderate 4 - Severe
() (1) (2) (3) (4) 4. Abdominal pain abo	 1 - Did not occur 2 - Mild 3 - Moderate 4 - Severe

5. Vomiting







{scercnt} {int 4} (number of times, "00" if none)
How many times was your low blood sugar so severe that you needed someone to help you but not ER visit or hospitalization)?
{schpcnt} {int 4} (number of times, "00" if none)
How many times have you had low blood sugar in the last 7 days?
{sclbcnt} {int 4} (number of times, "00" if none)
Did any of these times occur without symptoms?
() (1) 1 - Yes {scnosymp} {int 4} (2) 2 - No
Did any of these times result in injury to yourself or to others?
() (1) 1 - Yes {scinjury} {int 4} (2) 2 - No
Did any of these times occur when you were asleep?
() (1) 1 - Yes {scasleep} {int 4} (2) 2 - No
25. Was your blood sugar checked during the most severe episode of low blood sugar?
{sccheck} {int 4} (1) (2) 2 - No
What was the glucose value? {scgluc} {int 4}
26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?
() (1) 1 - Yes {scmedchg} {int 4} (2) 2 - No
Who changed your diabetes medicine?
() (1) 1 - Primary care physician (2) 2 - Look AHEAD personnel (3) 3 - Other, specify Specify: {scwho_sp} {varchar 50}

MY HEALTH, PART B. ANNUAL

Patient ID	[affix ID label here]	Date Form Completed Mon	th Day Year
Administration Ty	vpe Visit Code	Reviewed by	Language

A. Complaints

Below is a list of complaints people sometime have. For each item, check the one that best describes how bothersome the complaint was for you <u>during the past 4 weeks</u>. Be sure to mark one box for each complaint listed. If you did not have the problem, please check the box under "did not occur." If you had the complaint, use the following key to indicate how bothersome it was:

Mild = complaint did not interfere with usual activities.

Moderate = complaint interfered somewhat with usual activities.

Severe = complaint was so bothersome that usual activities could not be performed

	Complaint	Did not	Complaint occurred and was:		
	Complaint	occur	Mild	Moderate	Severe
1.	Heartburn	1	2	3	4
	(burning sensation in chest or upper abdomen)				
2.	Regurgitation	1	2	3	4
	(the involuntary movement of liquids or foods from the stomach up into the throat)				
3.	Nausea	1	2	3	4
	(feeling sick to your stomach as if you were going to throw up or vomit)				
4.	Abdominal pain above the navel	1	2	3	4
5.	Vomiting	1	2	3	4
6.	Feeling very full after eating only a little bit of a meal	1	2	3	4
7.	Bloating or distention	1	2	з 🗌	4
	(your abdomen feels swollen or gassy)				
8.	Constipation	1	2	3	4
9.	Diarrhea	1	2	з 🗌	4

	A. Complaints					
Complaint			Did not	Complaint occurred and was:		
	oomplaint		occur	Mild	Moderate	Severe
10.	Abdominal pain below the n	avel	1	2	3	4
11.	Leg or arm pain during or fo	llowing exercise	1	2	з 🗌	4
12.	Swollen or sore joints during	or following exercise	1	2	3	4
13.	A pulled or strained muscle, during or following exercise	tendon, or ligament	1	2	з 🗌	4
14.	Sores on your feet that heal	poorly	1	2	з 🗌	4
15.	Swelling of the feet or ankle	S	1	2	3	4
16.	Chest pain/angina/heart pai	n	1	2	3	4
17.	Palpitations/Heart racing/He	art skipping beats	1	2	з 🗌	4
18.	Shortness of breath with exe	ercise	1	2	3	4
19.	Shortness of breath lying do night	wn or waking you up at	1	2	з 🗖	4
20.	Dizzy or lightheaded when y	ou stand up	1	2	з 🗌	4
21.	Dizzy or lightheaded anytime	e	1	2	3	4
22.	Worsening of your eyesight		1	2	з 🗌	4
23.	Numbness or weakness of o	one arm or leg	1	2	3	4

	A. Comp	laints					
24. Have	4. Have you experienced low blood sugar in the last 3 months?						
₁Y		How many times was your low blood sugar so severe that you had to be in the hospital? (number of times, "00" if none) How many times was your low blood sugar so severe you had to visit the emergency room, but not be admitted to the hospital?					
		How many times was your low blood sugar so severe that you needed someone to help you (number of times, "00" if none) (but not ER visit or hospitalization)?					
	How many times have you had low blood sugar in the last 7 days?						
	Did any of these times occur without symptoms?						
	Did any of these times result in injury to yourself or to others? $_1 \square$ Yes $_2 \square$ No						
		Did any of these times occur when you were asleep?					
2 🗌	□ No → Go to Section B, "Knees," next page						
25. Was	25. Was your blood sugar checked during the most severe episode of low blood sugar?						
₁ _ ` Y	₁ _Yes → What was the glucose value?						
2	2 🗋 No						
26. Has	26. Has your medicine for diabetes been changed as a result of these episodes of low blood sugar?						
1 🗌 Y	∕es →	Who changed your diabetes medicines?					
2	No	₁ □Primary Care Physician					
		2 DLook AHEAD Personnel					
		3 Other					





