



(affix label here)

Patient ID Number	<input type="text"/>						
	Site	Sub-site	Sequential ID				

# PedsQL<sup>TM</sup>

## Diabetes Module

Version 3.0

**NOTE: All variables in the data have suffix "\_child"**

### TEEN REPORT (ages 13-18)

#### DIRECTIONS

Teens with diabetes sometimes have special problems. Please tell us **how much of a problem** each one has been for you during the **past ONE month** by circling:

- 0** if it is **never** a problem
- 1** if it is **almost never** a problem
- 2** if it is **sometimes** a problem
- 3** if it is **often** a problem
- 4** if it is **almost always** a problem

There are no right or wrong answers.  
If you do not understand a question, please ask for help.

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0904).

In the past **ONE month**, how much of a **problem** has this been for you ...

<b>ABOUT MY DIABETES (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. I feel hungry <b>hungry</b>	0	1	2	3	4
2. I feel thirsty <b>thirsty</b>	0	1	2	3	4
3. I have to go to the bathroom too often <b>bathroom</b>	0	1	2	3	4
4. I have stomachaches <b>stomach</b>	0	1	2	3	4
5. I have headaches <b>headache</b>	0	1	2	3	4
6. I go "low" <b>golow</b>	0	1	2	3	4
7. I feel tired or fatigued <b>tired</b>	0	1	2	3	4
8. I get shaky <b>shaky</b>	0	1	2	3	4
9. I get sweaty <b>sweaty</b>	0	1	2	3	4
10. I have trouble sleeping <b>sleep</b>	0	1	2	3	4
11. I get irritable <b>irritabl</b>	0	1	2	3	4

<b>TREATMENT - I (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. It hurts to prick my finger or give insulin shots <b>prick</b>	0	1	2	3	4
2. I am embarrassed about having diabetes <b>embarras</b>	0	1	2	3	4
3. My parents and I argue about my diabetes care <b>argue</b>	0	1	2	3	4
4. It is hard for me to stick to my diabetes care plan <b>stick</b>	0	1	2	3	4

Whether you do these things **on your own or with the help of your parents**, please answer how hard these things were to do in the past **ONE month**.

<b>TREATMENT II - (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. It is hard for me to take blood glucose tests <b>glucose</b>	0	1	2	3	4
2. It is hard for me to take insulin shots <b>insulin</b>	0	1	2	3	4
3. It is hard for me to exercise <b>exercise</b>	0	1	2	3	4
4. It is hard for me to keep track of carbohydrates or exchanges <b>carbo</b>	0	1	2	3	4
5. It is hard for me to wear my id bracelet <b>wearid</b>	0	1	2	3	4
6. It is hard for me to carry a fast-acting carbohydrate <b>fastact</b>	0	1	2	3	4
7. It is hard for me to eat snacks <b>snack</b>	0	1	2	3	4

<b>WORRY (problems with...)</b>	Never	Almost Never	Some-times	Often	Almost Always
1. I worry about "going low" <b>wrgolow</b>	0	1	2	3	4
2. I worry about whether or not my medical treatments are working <b>treatmnt</b>	0	1	2	3	4
3. I worry about long-term complications from diabetes <b>complica</b>	0	1	2	3	4

In the past **ONE month**, how much of a **problem** has this been for you ...

<b>COMMUNICATION (problems with...)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
1. It is hard for me to tell the doctors and nurses how I feel <b>tell</b> doc	0	1	2	3	4
2. It is hard for me to ask the doctors and nurses questions <b>ask</b> doc	0	1	2	3	4
3. It is hard for me to explain my illness to other people <b>explain</b>	0	1	2	3	4

<b>FOR STUDY USE ONLY</b>						
Date Completed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Completed by	<input type="text"/>
	Month	Day	Year			
Date Reviewed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Reviewer Code	<input type="text"/>
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Date Entered	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Data Entry Code	<input type="text"/>
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