

Questionnaire

Date:

Patient No.: _____

1. Sex: Male Female
2. Age: _____
3. What is your literacy level?
Able to read and write in Chinese
Unable to read and write in Chinese
4. How long had you had diabetes for?
Up to 10 years
10-15 years
 ≥ 15 years
5. How do you control your diabetes?
Using non-insulin treatment (Diet only/tablets/or both combined)
Using insulin treatment (insulin only or combining insulin with tablet or diet)
6. Do you think your diabetes is controlled?
Yes
No
Not sure
7. Do you think exercise is important to control diabetes?
Yes
No
Not sure
8. How many hours a week do you exercise such as cycling, swimming, jogging, and hiking?
<4 hours
 ≥ 4 hours
9. Does diabetes restrict your everyday activities?
Yes
No
Not sure
10. Can diabetes affect eyes?
Yes
No
Not sure
11. Have you attended diabetic eye examination previously?

- Yes
No
Not sure
12. Have you had any treatment in the eye other than glasses (like surgery, LASER) as a result of diabetes?
Yes
No
Not sure
13. How many times in the last year did you have to seek urgent medical help from hospital/doctor/nurse because your blood sugar was not controlled?
None
1-10 times
 ≥ 10 times
14. Do you take alcohol?
Yes
No
15. Do you smoke?
Yes
No
16. How often do you check your blood sugar?
At least once a month
From once a month to once within a year
17. How often in the last year did you forget to inject or take medicine?
0 times
1-5 times
 ≥ 5 times