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

# PedsQL<sup>TM</sup>

## Diabetes Module

Version 3.0

### PARENT REPORT for CHILDREN (ages 8-12)

#### DIRECTIONS

Children with diabetes sometimes have special problems. On the following page is a list of things that might be a problem for **your child**. Please tell us **how much of a problem** each one has been for **your child** 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.

In the past **ONE month**, how much of a **problem** has your child had with ...

<b>DIABETES (problems with...)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
1. Feeling hungry	0	1	2	3	4
2. Feeling thirsty	0	1	2	3	4
3. Having to go to the bathroom too often	0	1	2	3	4
4. Having stomachaches	0	1	2	3	4
5. Having headaches	0	1	2	3	4
6. Going "low"	0	1	2	3	4
7. Feeling tired or fatigued	0	1	2	3	4
8. Getting shaky	0	1	2	3	4
9. Getting sweaty	0	1	2	3	4
10. Having trouble sleeping	0	1	2	3	4
11. Getting irritable	0	1	2	3	4

<b>TREATMENT - I (problems with...)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
1. Needle sticks (i.e. injections/blood tests) causing him/her pain	0	1	2	3	4
2. Getting embarrassed about having diabetes	0	1	2	3	4
3. Arguing with me or my spouse about diabetes care	0	1	2	3	4
4. Sticking to his/her diabetes care plan	0	1	2	3	4

Whether your child does these things **independently or with your help**, please answer how difficult these things were to do in the past **ONE month**. (Note: This section is **not** asking about your child's independence in these areas, just how hard they were to do).

<b>TREATMENT - II (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 my child to take blood glucose tests	0	1	2	3	4
2. It is hard for my child to take insulin shots	0	1	2	3	4
3. It is hard for my child to exercise	0	1	2	3	4
4. It is hard for my child to track carbohydrates or exchanges	0	1	2	3	4
5. It is hard for my child to wear his/her id bracelet	0	1	2	3	4
6. It is hard for my child to carry a fast-acting carbohydrate	0	1	2	3	4
7. It is hard for my child to eat snacks	0	1	2	3	4

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

In the past **ONE month**, how much of a **problem** has your child had with ...

<b>COMMUNICATION (problems with...)</b>	<b>Never</b>	<b>Almost Never</b>	<b>Some-times</b>	<b>Often</b>	<b>Almost Always</b>
1. Telling the doctors and nurses how he/she feels	0	1	2	3	4
2. Asking the doctors or nurses questions	0	1	2	3	4
3. Explaining his/her illness to other people	0	1	2	3	4

**FOR STUDY USE ONLY**

Date Completed	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Completed by	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Month	Day	Year							
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Date Entered	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Data Entry Code	<input type="text"/>	<input type="text"/>	<input type="text"/>
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