

**Diabetes HealthSense  
Participant Pre Survey**

The National Diabetes Education Program is trying to find out how well the Diabetes HealthSense website can help people at risk for diabetes and people with diabetes. You will help improve Diabetes HealthSense by taking this survey. This survey will take you about 20 minutes to complete. The survey includes questions about you and your health. Unless the directions say otherwise, please choose one response for each question. Your survey answers are private.

Public reporting burden for this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the 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: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx\*). Do not return the completed form to this address.

**ID Code**

**To keep your responses private an ID code will be created using the following information.**

Please write down **YOUR first and last initials:**

[Example: Jane Smith is J.S.; Jane Doe-Smith is J.D.]

\_\_\_\_\_ / \_\_\_\_\_  
First Initial      Last Initial

What is your **MONTH and YEAR** of BIRTH?

[Ex: Write 05/95 if your birthday is May 22, 1995]

\_\_\_\_\_ / \_\_\_\_\_  
MM      YR

**Please choose your program location:**

- |                                 |                                  |                                  |
|---------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Site 1 | <input type="checkbox"/> Site 6  | <input type="checkbox"/> Site 12 |
| <input type="checkbox"/> Site 2 | <input type="checkbox"/> Site 7  | <input type="checkbox"/> Site 12 |
| <input type="checkbox"/> Site 3 | <input type="checkbox"/> Site 8  | <input type="checkbox"/> Site 13 |
| <input type="checkbox"/> Site 4 | <input type="checkbox"/> Site 9  | <input type="checkbox"/> Site 14 |
| <input type="checkbox"/> Site 5 | <input type="checkbox"/> Site 10 | <input type="checkbox"/> Site 15 |

**Resources**

**1. How often do you look for information on preventing or managing diabetes?**

- Never     Rarely     Sometimes     Often





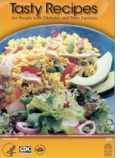
**2. Where have you received or found information about diabetes prevention and management? (Choose one or more)**

- Health care provider
- Mass media (such as TV, radio, newspaper)
- Social media (such as Facebook)
- Internet
- Mail
- Friends/family
- Diabetes education class or program
- Professional associations
- None of the above

3. In the last month, have you participated in a diabetes education class or program? (For example, attended one or more individual or group classes or meetings with a diabetes educator, nurse or dietitian?)

- No
- Yes

3a. If Yes, please specify: \_\_\_\_\_

4. How would you describe your experience with these NDEP resources?		Never heard of it	Heard of it but do not have it	Have it but have not used it	Have it and used it once	Have it and use it a lot
a. <i>Small Steps. Big Rewards: Your GAMEPLAN to Prevent Type 2 Diabetes</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. <i>4 Steps to Manage Your Diabetes for Life</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. <i>Choose More than 50 Ways to Prevent Diabetes</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. <i>Paso a Paso</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. <i>Tasty Recipes for people with diabetes</i>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. How often in the past month have you used the...	Never	Once this month	2-3 times this month	Once a week	More than once a week
a. NDEP Diabetes HealthSense Website	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The American Diabetes Association Website (Diabetes.org)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Risk**

6. Has a doctor or other health professional ever told you that you: (Choose one or more)

- Have Type 1 diabetes
- Have Type 2 diabetes
- Have prediabetes or borderline diabetes

- Have high blood glucose (blood sugar), impaired fasting glucose, or impaired glucose tolerance?
- Are at risk for diabetes

**7. Which, if any, of the following is true for you? (Choose one or more)**

- I have a mother, father, sister, or brother with diabetes
- I have been told by a doctor or other health professional that I have high blood pressure
- I have been told by a doctor or other health professional that I have high cholesterol
- I am NOT physically active
- I was diagnosed with gestational diabetes during any of my pregnancies
- I have given birth to a baby weighing 9 pounds or more
- I smoke

**Knowledge and Behaviors**

**8. Which of the following can quickly raise your blood glucose (blood sugar)?**

- Baked chicken
- Swiss cheese
- Baked potato
- Peanut butter

**9. Eating foods lower in saturated and trans fat decreases your risk for:**

- Nerve disease
- Kidney disease
- Heart disease
- Eye disease

**10. The A1C is a measure of your average blood glucose (blood sugar) for the past:**

- Day
- Week
- 2-3 months
- 6 months

**11. Which should not be used to treat low blood glucose (blood sugar)?**

- 3 hard candies
- 1/2 cup orange juice
- 1 cup diet soft drink
- 1 cup skim milk

**12. Which of the following is the least amount of physical activity you should do to prevent or manage diabetes?**

- 30 minutes of activity, five times a week (or 150 minutes per week)
- 10 minutes of activity, seven days a week (or 70 minutes per week)
- 45 minutes of activity, six days a week (or 270 minutes per week)

**13. Which of the following exercise programs includes a mix of strength, flexibility and aerobic activities?**

- Walking, running, and swimming
- Lifting weights, push-ups, sit-ups
- Walking, lifting weights, stretching
- Stretching, deep breathing, meditating

**14. The best way to lose weight is to:**

- Limit amount of physical activity
- Increase portion sizes
- Combine healthy eating and exercise
- Reduce dietary fat without reducing calories

**15. Which of the following factors contribute to a person's weight? (Choose one or more)**

- Family history and genetics
- Environment
- Metabolism
- Behavior or habits

**16. The best way to take care of your feet is to:**

- Check them each day for cuts, blisters and swelling
- Massage them with alcohol each day
- Soak them for one hour each day
- Buy shoes a size larger than usual

**17. People with diabetes whose blood glucose (blood sugar) is out of control are at greater risk of which complications? (Choose one or more)**

- Serious eye problems
- Circulation problems
- Kidney Problems
- Allergy problems
- Gum disease
- Heart attack or stroke

**18. Which of the following may be a sign of an emotional low and/or depression in a person with diabetes? (Choose one or more)**

- Sleeps most of the day
- Does not have an interest or find pleasure in activities
- Does not feel in control of their diabetes
- Discusses diabetes care with family and friends

**19. Depression can raise your blood glucose (blood sugar) by causing you to eat too much, do too little, and reduce your motivation to take care of yourself.**

- True
- False

**20. Which of the following steps are important ways to help you achieve your goals? (Choose one or more.)**

- Making a plan with realistic goals
- Tracking progress
- Avoiding rewards
- Using a support system

**For each statement, please check the option that best describes your behaviors.**

<b>21. Have you:</b>	<b>No, and I do not plan to</b>	<b>No, but I plan to within the next 6 months</b>	<b>No, but I plan to within the next month</b>	<b>Yes, I started this less than 6 months</b>	<b>Yes, I have been doing this for</b>
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				ago	6 months or longer
a. Looked for resources to help you learn about or help you manage your diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Set a healthy eating or weight loss goal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Reduced the amount of fat in your diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Reduced the number of calories you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Kept track of what you eat and drink most days of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Set a physical activity goal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fit exercise into your daily routine (for example, took the stairs instead of elevator, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Exercised for 30 minutes at least 5 days a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Kept track of your physical activity most days of the week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**22. Are you seriously thinking of quitting smoking?**

- I have never smoked or I quit more than 6 months ago
- I am not thinking of quitting
- I plan to quit within the next 6 months
- I plan to quit within the next 30 days
- I quit within the last 6 months

Please indicate the degree to which each of the following items may be bothering you. If you feel that a particular item is not a bother or a problem for you, you would check "1." If it is very bothersome to you, you might check "6."

23. How much do the following feelings bother you in your life?	Not a problem		Moderate Problem		Serious Problem	
	1	2	3	4	5	6
a. Feeling overwhelmed by the demands of living with diabetes or at risk of developing diabetes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Often feeling that I am failing with my diabetes or diabetes prevention regimen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. How confident do you feel that you can...	Not At All Confident					Totally Confident
	1	2	3	4	5	6
a. Find resources to help you learn about or manage your diabetes or your risk for diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Set a healthy eating or weight loss goal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Reduce the amount of fat in your diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Reduce the number of calories you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Keep track of what you eat and drink most days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Set a physical activity goal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Fit exercise into your daily routine (for example, take the stairs instead of elevator, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Exercise for 30 minutes at least 5 days a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Keep track of your physical activity most days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. How confident do you feel that you can follow your health care provider's recommendations for...	Not At All Confident					Totally Confident	Does Not Apply
	1	2	3	4	5	6	
a. Checking your blood glucose (blood sugar).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Taking medications for diabetes, blood pressure, cholesterol, or heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Checking your blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Checking your feet for redness or sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. Think back over the past month. How often did you...	Never	Rarely	Sometimes	Often	All of the time
a. Fill half of your plate with fruits and vegetables at each meal?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Reduce the amount of fat in your diet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Reduce the number of calories you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Reduce the number of unhealthy snacks and desserts/sweets you eat?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Reduce your portion sizes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Choose drinks without added sugar like diet sodas and unsweetened tea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Follow your diet goals and plans?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Track your diet to measure progress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

27. Think back over the past month. How often	Never	Rarely	Sometimes	Often	All of the
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did you...					time
a. Exercise for 30 minutes at least 5 days a week?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Fit exercise into your daily routine (for example, take stairs instead of elevator, etc)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Do different types of exercises such as stretching, strength training, walking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Follow your exercise goals and plans?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Track your exercise to measure progress?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. Think back over the past month. How often did you do the following to cope with stress and emotions?	Never	Rarely	Sometimes	Often
a. Exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Use relaxation techniques such as meditation or deep breathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Participate in a support group?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Use the support of family and friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Participate in enjoyable hobbies?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Participate in faith-based activities?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

29. Think back over the past month. How often did you follow your health care provider's recommendations for...	Never	Rarely	Sometimes	Often	All of the time	Does not apply
a. Checking your blood glucose (blood sugar).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Taking medications for diabetes, blood pressure, cholesterol, or heart disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Checking your blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Checking your feet for redness or sores?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## About You

30. What is your gender?

- Female
- Male

31. How old are you?

- Under 25
- 25-34
- 35-44
- 45-54
- 55-64
- 65+

32. What is your height? \_\_\_\_\_ feet and inches

33. What is your weight? \_\_\_\_\_ lbs

34. Are you Hispanic or Latino?

- No
- Yes

35. What is your race? (*Choose one or more*)

- Black or African American
- White
- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander
- Asian

36. Is English your primary language?

- No
- Yes

37. What is the highest level of education you have completed?

- Some high school (grades 9-11)
- High school degree or GED
- Associate degree (2-year)
- College degree (4-year)
- Graduate degree

38. Please check the category that represents your annual household income.

- Less than \$15,000
- \$15,000-\$35,000
- \$36,000-\$50,000
- \$51,000-\$75,000
- Over \$75,000

39. How often do you use the internet at home?

- Rarely or Never
- 2-3 times a month
- Once a week
- 2-3 times a week
- Daily



**40. How often do you need to have someone help you understand written instructions, pamphlets, or other materials from your doctor or pharmacy?**

- Never       Rarely       Sometimes       Often       Always