**Assigned study ID: \_\_ \_\_ \_\_ (Office use only)**

**Section A:** The following statements describe self-care activities related to your diabetes. Thinking about your self-care over the past 8 weeks, please specify the extent to which each statement applies to you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Statements** | **Applies to me very much** | **Applies to me to a considerable degree** | **Applies to me to some degree** | **Does not apply to me** |
| **1.** I check my blood sugar levels with care and attention | ☐ | ☐ | ☐ | ☐ |
| **2.** The food I choose to eat makes it easy to achieve optimal blood sugar level. | ☐ | ☐ | ☐ | ☐ |
| **3.** I keep all doctors' appointments recommended for my diabetes treatment. | ☐ | ☐ | ☐ | ☐ |
| **4.** I take my diabetes medication (e.g insulin, tablets) as prescribed | ☐ | ☐ | ☐ | ☐ |
| **5.** Occasionally I eat lots of sweets or other foods rich in carbohydrate | ☐ | ☐ | ☐ | ☐ |
| **6.** I record my blood sugar levels regularly (or analyse the value chart with my blood glucose meter). | ☐ | ☐ | ☐ | ☐ |
| **7.** I tend to avoid diabetes related doctors' appointments. | ☐ | ☐ | ☐ | ☐ |
| **8.** I do regular physical activities to achieve optimal sugar levels. | ☐ | ☐ | ☐ | ☐ |
| **9.** I strictly follow the dietary recommendations given by my doctor or diabetes specialist. | ☐ | ☐ | ☐ | ☐ |
| **10.** I do not check my blood sugar levels frequently enough as would be required for achieving good blood glucose control. | ☐ | ☐ | ☐ | ☐ |
| **11.** I avoid physical activities, although it could improve my diabetes. | ☐ | ☐ | ☐ | ☐ |
| **12.** I tend to forget to take or skip my diabetes medication (e.g insulin, tablets). | ☐ | ☐ | ☐ | ☐ |
| **13.** Sometimes I have real "food binges'' (uncontrollable eating). | ☐ | ☐ | ☐ | ☐ |
| **14.** Regarding my diabetes care, I should see my health care provider more often. | ☐ | ☐ | ☐ | ☐ |
| **15.** I tend to skip planned physical activity**.** | ☐ | ☐ | ☐ | ☐ |
| **16.** My diabetes self-care is poor. | ☐ | ☐ | ☐ | ☐ |

**Section B:** Here are some statements about diabetes, some are true statements and some are false. Please read each statement and then indicate whether you think it is true or false by putting a circle round either TRUE or FALSE. If you do not know the answer, please put a circle around DON’T KNOW.

|  |  |  |  |
| --- | --- | --- | --- |
| **Statements** | **True** | **False** | **Don’t know** |
| 1. **The diabetes diet is a healthy diet for most people**
 |  [ ]  [ ]  [ ]  |
| 1. **Glycosylated haemoglobin (HbA1c) is a test that measures your average blood glucose levels in the previous 2 weeks**
 |  [ ]  [ ]  [ ]  |
| 1. **200g of chicken has more carbohydrate in it than 200g of potatoes**
 |  [ ]  [ ]  [ ]  |
| 1. **Orange juice has more fat in it than low fat milk**
 |  [ ]  [ ]  [ ]  |
| 1. **Urine testing and blood testing are both equally good for testing the level of blood glucose**
 |  [ ]  [ ]  [ ]  |
| 1. **Unsweetened fruit juice raises blood glucose levels**
 |  [ ]  [ ]  [ ]  |
| 1. **A can of diet soft drink can be used for treating low blood glucose levels**
 |  [ ]  [ ]  [ ]  |
| 1. **Using olive oil in cooking can help lower the cholesterol in your blood**
 |  [ ]  [ ]  [ ]  |
| 1. **Exercising regularly can help reduce high blood pressure**
 |  [ ]  [ ]  [ ]  |
| 1. **For a person in with blood glucose levels within targets range, exercise has no effect on blood glucose levels**
 |  [ ]  [ ]  [ ]  |
| 1. **Infection is likely to cause an increase in blood sugar level**
 |  [ ]  [ ]  [ ]  |
| 1. **Wearing shoes a size bigger than usual helps prevent foot ulcers**
 |  [ ]  [ ]  [ ]  |
| 1. **Eating foods lower in fat decreases your risk for heart disease**
 |  [ ]  [ ]  [ ]  |
| 1. **Numbness and tingling may be symptoms of nerve disease**
 |  [ ]  [ ]  [ ]  |
| 1. **Lung problems are usually associated with having diabetes**
 |  [ ]  [ ]  [ ]  |
| 1. **When you are sick with the flu you should test for glucose more often**
 |  [ ]  [ ]  [ ]  |
| 1. **High blood glucose levels may be caused by too much insulin.**
 |  [ ]  [ ]  [ ]  |
| 1. **If you take your morning insulin but skip breakfast, your blood glucose level will usually decrease**
 |  [ ]  [ ]  [ ]  |
| 1. **Having regular check-ups with your doctor can help spot the early signs of diabetes complications**
 |  [ ]  [ ]  [ ]  |
| 1. **Attending your diabetes appointments will stop you getting diabetes complications**
 |  [ ]  [ ]  [ ]  |

**Section C:** The table below relates to your medication taking behavior. There is no right or wrong answer. Please answer each question based on your personal experience with your diabetes medication. Circle only one response per question.

|  |  |  |
| --- | --- | --- |
| Questions | **Yes**  | **No** |
| 1. **Do you ever forget to take your medication?**
 |  |  |
| 1. **When you feel better do you sometimes stop taking your medication?**
 |  |  |
| 1. **Sometimes if you feel worse when you take the medication, do you stop taking it?**
 |  |  |
| 1. **Do you take your medication only when you are sick?**
 |  |  |
| 1. **Is it unnatural for your mind and body to be controlled by medication?**
 |  |  |
| 1. **Are your thoughts clearer on medication?**
 |  |  |
| 1. **By staying on medication, do you think you can prevent getting sick?**
 |  |  |
| 1. **Does your medication make you feel weird and cranky?**
 |  |  |
| 1. **Do you sometimes care less about taking your medication?**
 |  |  |
| 1. **Does your medication makes you feel tired and sluggish?**
 |  |  |
| 1. **Do you currently take herbal therapies (e.g tablets, teas, tinctures) to manage your diabetes?**

**If Yes, please list all the herbal therapies that you take: ……………………………………………………………..****……………………………………………………………..****……………………………………………………………..** **…………………………………………………………….** |  |  |

**Section D:** These questions ask how you have been **feeling** in the past week. Pleasant and unpleasant feelings of several kinds and extents are covered. Please tick **only one** response that best describes your situation as it has been over the past week.

|  |  |
| --- | --- |
| 1. **How much energy do you have to do things you want to do?**
 | **I am**[ ]  Always full of energy [ ]  Occasionally full of energy[ ]  Usually full of energy [ ]  Usually tired and lacking energy |
| 1. **How often do you feel socially excluded or left out?**
 | [ ]  Never [ ]  Sometimes [ ]  Always[ ]  Rarely [ ]  Often |
| 1. **How easy or difficult is it for you to get around by yourself outside your place of residence (eg. to go shopping, visiting)?**
 | [ ]  Getting around is enjoyable and easy[ ]  I have no difficulty getting around outside my place of residence[ ]  A little difficult [ ]  Moderately difficult[ ]  A lot of difficulty[ ]  I cannot get around unless somebody is there to help me |
| 1. **Does your health affect your role in your community (e.g. residential, sporting, church or cultural** **activities)?**
 |  [ ]  My role in the community is unaffected by my health[ ]  There are some parts of my community role I cannot carry out[ ]  There are many parts of my community role I cannot carry out[ ]  I cannot carry out any part of my community role |
| 1. **How often do you feel sad?**
 | [ ]  Never [ ]  Rarely [ ]  Some of the time [ ]  Usually[ ]  Nearly all the time |
| 1. **How often do you experience serious pain?**
 | **I experience it**[ ]  Very rarely [ ]  Less than once a week[ ]  Three to four times a week[ ]  Most of the time |
| 1. **How much confidence do you have in yourself?**
 | [ ]  Complete confidence [ ]  A lot[ ]  A moderate amount [ ]  A little[ ]  None at all |
| 1. **Do you normally feel calm and tranquil or agitated?**
 | [ ]  Always calm and tranquil[ ]  Usually calm and tranquil,[ ]  Usually calm and tranquil, sometimes agitated[ ]  Usually agitated [ ]  Always agitated |
| 1. **Does your health affect your relationship with your family?**
 | [ ]  My role in the family is unaffected by my health[ ]  There are some parts of my family role I cannot carry out [ ]  There are many parts of my family role [ ]  I cannot carry out[ ]  I cannot carry out any part of my family role |
| 1. **How satisfying are your close relationships (family and friends)?**
 | [ ]  Very satisfying[ ]  Satisfying[ ]  Neither satisfying nor dissatisfying[ ]  Unpleasant[ ]  Very unpleasant  |
| 1. **How well do you communicate with others (talking, signing, texting, being understood by others and** **understanding them)?**
 | [ ]  I have no trouble being understood[ ]  I have some difficulty being understood [ ]  I have some difficulty being understood by people who do not know me[ ]  I am understood only by people who knows me[ ]  I cannot adequately communicate with others |
| 1. **How often do you have trouble sleeping?**
 | [ ]  Never [ ]  Often[ ]  Almost never [ ]  All the time[ ]  Sometimes |
| 1. **Do you at any time feel worthless?**
 | [ ]  Never [ ]  Usually[ ]  Almost never [ ]  Always[ ]  Sometimes |
| 1. **How often do you feel angry?**
 | [ ]  Never [ ]  Often[ ]  Almost never [ ]  All the time[ ]  Sometimes |
| 1. **How easy or difficult is it for you to move around (using any aids or equipment you need e.g a** **wheelchair, frame or stick)?**
 | [ ]  I am very mobile[ ]  I have no difficulty with mobility[ ]  I have some difficulty with mobility. I can go short distances only[ ]  I have a lot of difficulty with mobility. I need someone to help[ ]  I am bedridden. |
| 1. **Do you ever feel like hurting yourself?**
 | [ ]  Never [ ]  Often[ ]  Rarely [ ]  All the time[ ]  Sometimes |
| 1. **How enthusiastic do you feel?**
 | [ ]  Very [ ]  Not at all[ ]  Somewhat [ ]  Not much |
| 1. **How often did you feel worried in the last 7 days?**
 | [ ]  Never [ ]  Often[ ]  Occasionally [ ]  All the time[ ]  Sometimes |
| 1. **How difficult is it for you to wash, toilet, dress yourself, eat or care for your appearance**
 | [ ]  These things are very easy for me to do [ ]  I have no difficulty in doing these things[ ]  I find some of these things difficult, but I manage to do them on my own[ ]  Many of these things are difficult, and I need help to do them [ ]  I cannot do these things by myself at all |
| 1. **How often do you feel happy?**
 | [ ]  All the time [ ]  Almost never[ ]  Mostly [ ]  Never[ ]  Sometimes |
| 1. **How much do you feel you can cope with life’s problems?**
 | [ ]  Completely [ ]  Almost never[ ]  Mostly [ ]  Never[ ]  Sometimes |
| 1. **How much pain or discomfort do you experience?**
 | [ ]  None at all[ ]  I have moderate pain[ ]  I suffer from severe pain[ ]  I suffer unbearable pain |
| 1. **How much do you enjoy your close relationships (family and friends)?**
 | [ ]  Immensely [ ]  Not much[ ]  A lot [ ]  I hate it[ ]  A little |
| 1. **How often does pain interfere with your usual activities?**
 | [ ]  Never [ ]  Often[ ]  Rarely [ ]  Always[ ]  Sometimes |
| 1. **How often do you feel pleasure?**
 | [ ]  Always [ ]  Almost never[ ]  Usually [ ]  Never[ ]  Sometimes |
| 1. **How much of a burden do you feel you are to other people?**
 | [ ]  Not at all [ ]  A lot[ ]  A little [ ]  Totally[ ]  A moderate amount |
| 1. **How content are you with your life?**
 | [ ]  Extremely [ ]  Slightly[ ]  Mainly [ ]  Not at all[ ]  Moderately |
| 1. **How well can you see (using glasses or contact lenses if they are needed)?**
 | [ ]  I have excellent sight[ ]  I see normally[ ]  I have some difficulty seeing things sharply. (e.g. small print, objects in the distance, or watching television)[ ]  I have a lot of difficulty seeing sharply[ ]  I only see general shapes[ ]  I cannot see at all |
| 1. **How often do you feel in control of your life?**
 | [ ]  Always [ ]  Only occasionally[ ]  Mostly [ ]  Never[ ]  Sometimes |
| 1. **How much help do you need with jobs around your place of residence (e.g preparing food, cleaning, gardening)?**
 | [ ]  I can do all these tasks very easily without any help[ ]  I can do these tasks relatively easily without help[ ]  I can do most of these tasks unless I have help[ ]  I cannot do most of these tasks unless I have help[ ]  I cannot do none of these tasks myself. |
| 1. **How often do you feel socially isolated?**
 | [ ]  Never [ ]  Often[ ]  Rarely [ ]  Always[ ]  Sometimes |
| 1. **How well can you hear (using your hearing aid if needed)?**
 | [ ]  I have excellent hearing[ ]  I hear normally[ ]  I have some difficulty hearing or I do not hear clearly[ ]  I have difficulty hearing things clearly. Often I do not understand what is said. I usually do not take part in conversation because I cannot hear what is said[ ]  I hear very little[ ]  I am unable to hear at all |
| 1. **How often do you feel depressed?**
 | [ ]  Never [ ]  Often[ ]  Almost never [ ]  Very often[ ]  Sometimes [ ]  All the time |
| 1. **How happy are you with your close and intimate relationships?**
 | [ ]  Very happy [ ]  Generally happy[ ]  Neither happy nor unhappy [ ]  Generally unhappy[ ]  Very unhappy  |
| 1. **How often did you feel in despair in the last seven days?**
 | [ ]  Never [ ]  Often[ ]  Occasionally [ ]  All the time[ ]  Sometimes  |

**Section E: Socio-Demographic Characteristics and Family Medical history**

**Please read and consider each of the following questions carefully. Your candid responses are essential to ensure the reliability of this study. Please ensure that you answer all the questions.**

|  |  |
| --- | --- |
| **Gender** | [ ]  Male [ ]  Female |
| **Age** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years |
| **Date of Birth** | \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_Day / Month / Year |
| **Highest Level of Educational Qualification (completed)** | [ ]  Year 10 (Junior High School) [ ]  Year 12 (Senior High School)[ ]  TAFE (Technical College) [ ]  First degree[ ]  Postgraduate degree[ ]  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **What suburb do you live in**? |  |
| **Employment Status** | [ ]  Retired [ ]  Unemployed [ ]  Part-time employment [ ]  Full time employment |
| **Family’s Annual Income (excluding tax and fringe benefit)** | [ ]  ≤ $50,000 [ ]  $51,000 – 80,000 [ ] $81,000–100,000 [ ]  $101,000 – 150,000 [ ] $151,000 – 200,000 [ ]  over $200,000[ ]  Prefer not to say |
| **How long have you been diagnosed with diabetes (years)?** | [ ]  <1 [ ]  1- 5 [ ]  6 -10 [ ]  11- 15 [ ]  ≥ 15  |
| **What type of diabetes do you have?** | [ ]  Type 1 [ ]  Type 2 |
| **Your present Fasting Blood Glucose target recommended by your health care team** | \_\_\_\_\_\_\_\_\_\_\_mmol/L |

**Genetics / Family History**

The following questions are on you and your family genetic and medical history. The questions refer to your direct **blood relatives** only: that is those related to you by birth and not adoption or marriage (e.g step sons and step daughters). Please answer the questions to the best of your ability.

1. **How would you describe your ancestry (check all that apply):**

[ ] Aboriginal [ ]  Asian [ ]  African [ ]  Pacific Islander

[ ]  Torres Strait Islander [ ]  Caucasian

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Do you have any biological children?**

[ ]  No **(Please go to question 6)**

[ ]  Yes I**f “Yes’’, specify**

[ ]  Male (s). How many? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

[ ]  Female(s). How many? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

1. **Have any of your children been diagnosed with diabetes previously?**

[ ]  Yes

[ ]  No **(Please go to question 6)**

[ ]  Not aware **(Please go to question 6)**

1. **How many of your children have been diagnosed with type 1 diabetes?**

Male(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Female(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

1. **How many of your children have been diagnosed with type 2 diabetes?**

Male(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Female(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

1. **Has any of your parents been diagnosed with diabetes previously?**

[ ]  Yes **(Please go to question 7)**

[ ]  No **(Please go to question 8)**

[ ]  Not aware **(Please go to question 8)**

1. **If “Yes”, specify:**

[ ]  Mother Type 1 [ ]  Type [ ]

[ ]  Father Type 1 [ ]  Type [ ]

[ ]  Both parents Type 1 [ ]  Type [ ]

1. **Do you have siblings?**

[ ]  No **(Please go to question 11)**

[ ]  Yes. If “Yes, specify:

Brother(s). How many? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Sister(s). How many? [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

1. **Has any of your siblings been diagnosed with type 1 diabetes previously?**

[ ]  None

[ ]  Brother(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

[ ]  Sister (s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

[ ]  Not aware

1. **Has any of your siblings been diagnosed with type 2 diabetes previously?**

[ ]  None

[ ]  Brother(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

[ ]  Sister (s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

[ ]  Not aware

1. **Please indicate, how many of your specific relatives have been diagnosed with type 1 diabetes.**

None [ ]

Aunt(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Uncle(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Cousin(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Others(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Not aware [ ]

1. **Please indicate, how many of your specific relatives have been diagnosed with type 2 diabetes.**

None [ ]

Aunt(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Uncle(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Cousin(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Others(s) [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  More than 4

Not aware [ ]

1. **Does anyone among your blood relatives (brothers, sisters, children, parents, grandparents, aunts, uncles, nephew, niece and cousins, e.t.c) have any of the following medical conditions**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Medical conditions** | **No** | **Yes** | **Do****Not****Know** | **If Yes, please provide the relationship to you; either on your paternal or maternal side** |
|  |  |  |  | **Maternal relationship** | **Paternal relationship** |
| **Example: Hypertension** |   |   |  | grandmother | Uncle, Cousin |
| Kidney disease |   |   |  |   |   |
| Hypertension (High blood pressure) |   |   |  |   |   |
| Obesity |   |   |  |   |   |
| Cardiovascular disease |   |   |  |   |   |
| Dyslipidaemia (Abnormal cholesterol levels) |   |   |  |   |   |
| Non-alcoholic fatty liver disease |   |   |  |   |   |
| Heart attack |   |   |  |   |   |
| Heart failure |   |   |  |   |   |
| Sleep disorder |   |   |  |   |   |
| Cancer (any form) |   |   |  |   |   |
| Depression |   |   |  |   |   |
| Stroke |   |   |  |   |   |
| Angina (Unexplained chest pain) |   |   |  |   |   |
|  |   |   |  |   |   |

**Thank you for taking the time to fill out this questionnaire**