



Exit Survey

Thank you for agreeing to take part in this important survey!

Your responses will help us improve this PeerSupport Wellness program for future participants. Please answer all questions to the best of your ability. This survey should take approximately 1 hour to complete. Your responses are voluntary and will be confidential. If you have any questions or concerns, please contact one of the peer leaders in your program.

Thank you!

1. Today's date (M-D-Y): _____

2. Participant Identification Code: _____

3. Your role: Participant Peer Leader

Part 1: Clinical Data

4. Date of clinical data collection (M-D-Y): _____

5. Height (in): _____ 6. Weight (lbs): _____

7. BMI: _____ 8. Blood pressure (mmHg): _____

9. Current diagnoses: _____

10. Year of diagnosis (M-D-Y): _____

Part 2: Demographics

11. Date of birth (M-D-Y): _____ 12. Gender: _____

13. Highest level of education:

- No education Elementary High school Some college/
university
 Bachelors Masters PhD/doctorate

14. Marital status:

- Single, never married Married or domestic partnership
 Divorced Widowed Separated

15. Employment status:

- Employed for wages A homemaker Military
 Self-employed A student Retired
 Out of work and looking for work Out of work and looking for work Unable to work

16. Household income:

- Less than \$20,000 \$35,000-\$49,999 \$75,000-\$999,999
 \$20,000-\$34,999 \$50,000-\$74,999 \$100,00 or more

17. Zipcode: _____

18. How many cell phones do you have for personal use? _____

19. How many children less than 18 years of age live in your household? _____

Part 3: Exercise

20. During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- Yes No Don't know / not sure

Part 4: Sleep

21. On average, how many hours of sleep do you get in a 24-hour period? _____

Part 5: Tobacco Use

22. Have you smoked at least 100 cigarettes in your entire life?

- Yes No Don't know / not sure

23. Have you smoked at least 100 cigarettes in your entire life?

- Every day Some days Not at all Don't know / not sure

Part 6: Alcohol Consumption

24. During the past 30 days, how many days per week or per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage or liquor? _____

25. One drink is equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. During the past 30 days, on the days when you drank, about how many drinks did you drink on the average? _____

Part 7: Medication Adherence

26. How often do you miss scheduled appointment?

None of the time Some of the time Most of the time All of the time

27. How often do you forget to take your medicine?

None of the time Some of the time Most of the time All of the time

28. How often do you decide not to take your medicine?

None of the time Some of the time Most of the time All of the time

29. How often do you forget to get prescriptions filled?

None of the time Some of the time Most of the time All of the time

30. How often do you run out of medicine?

None of the time Some of the time Most of the time All of the time

31. How often do you skip a dose of your medicine before you go to the doctor?

None of the time Some of the time Most of the time All of the time

32. How often do you miss taking you medicine when you feel better?

None of the time Some of the time Most of the time All of the time

33. How often do you miss taking your medicine when you feel sick?

None of the time Some of the time Most of the time All of the time

34. How often do you take someone else's medicine?

None of the time Some of the time Most of the time All of the time

35. How often do you miss taking your medicine when you are careless?

- None of the time Some of the time Most of the time All of the time

36. How often do you change the dose of your medicines to suit your needs (like when you take more or less pill than you're supposed to)?

- None of the time Some of the time Most of the time All of the time

37. How often do you forget to take your medicine when you are supposed to take it more than once a day?

- None of the time Some of the time Most of the time All of the time

38. How often do you put off refilling your medicines because they cost too much money?

- None of the time Some of the time Most of the time All of the time

39. How often do you plan ahead and refill your medicines before they run out?

- None of the time Some of the time Most of the time All of the time

Part 8: Medication Confidence

How confident are you that you can take your medications correctly...

40. ... when you take several different medicines each day?

- Not confident Somewhat confident Very confident

41. ... when you have a busy day planned?

- Not confident Somewhat confident Very confident

How confident are you that you can take your medications correctly...

42. ... when you take several different medicines each day?

Not confident Somewhat confident Very confident

43. ... when no one reminds you to take the medicine?

Not confident Somewhat confident Very confident

44. ... when you take medicines more than once a day?

Not confident Somewhat confident Very confident

45. ... when the schedule to take the medicine is not convenient?

Not confident Somewhat confident Very confident

46. ... when your normal routine gets messed up?

Not confident Somewhat confident Very confident

47. ... When you get a refill of your old medicine and some of the pills look different than usual?

Not confident Somewhat confident Very confident

48. ... when you are not sure how to take the medicine?

Not confident Somewhat confident Very confident

49. ... when you are not sure what time of the day to take your medicine?

Not confident Somewhat confident Very confident

How confident are you that you can take your medications correctly...

50. ... when a doctor changes your medicines?

Not confident Somewhat confident Very confident

51. ... when they cause some side effects?

Not confident Somewhat confident Very confident

52. ... when you are feeling sick (like having a cold or the flu)?

Not confident Somewhat confident Very confident

Part 9: Health Care Access

53. Not including over the counter (OTC) medications, was there a time in the past 12 months when you did not take your medication as prescribed because of cost?

Yes No No medication was prescribed Don't know / not sure

Part 10: Quality of Life

Please indicate which statements best describe your own health state today by selecting one answer in each group below.

54. Mobility

I have no problems in walking about I have some problems in walking about I am confined to bed

55. Self-Care

I have no problems with self-care I have some problems washing or dressing myself I am unable to wash or dress myself

Part II: Diabetes

Please answer the following questions only if you have a current diagnosis of Diabetes.

60. Are you now taking insulin?

Yes

No

Don't know / not sure

61. About how often do you check your blood for glucose or sugar? _____

62. Including times when checked by a family member or friend, about how often do you check your feet for any sores or irritations? _____

63. About how many times in the past 12 months have you seen a doctor, nurse, or other health professional for your diabetes? _____

64. About how many times in the past 12 months has a doctor, nurse, or other health professional checked you for A1C? _____

65. About how many times in the past 12 months has a health professional checked your feet for any sores or irritations? _____

66. When was the last time you had an eye exam in which the pupils were dilated, making you temporarily sensitive to bright light?

Within the past month

Within the past year

Within the past 2 years

2 or more years ago

Don't know/Not sure

Never

67. Has a doctor ever told you that diabetes has affected your eyes or that you had retinopathy?

Yes

No

Don't know / not sure

68. Have you ever taken a course or class in how to manage your diabetes yourself?

Yes

No

Don't know / not sure

Part 12: Dietary Assessment

Over the past few months:

69. How many times a week did you eat fast food meals or snacks?

- Less than 1 times 1-3 times 4 or more times

70. How many servings of fruit did you eat each day?

- 5 or more 3-4 servings 2 or less

71. How many servings of vegetables did you eat each day?

- 5 or more 3-4 servings 2 or less

72. How many regular sodas or glasses of sweet tea did you drink each day?

- Less than 1 1-2 3 or more

73. How many times a week did you eat beans (like pinto or black beans), chicken, or fish?

- 3 or more times 1-2 times Less than 1 times

74. How many times a week did you eat regular snack chips or crackers (not low-fat)?

- 1 time or less 2-3 times 4 or more times

75. How many times a week did you eat desserts and other sweets (not the low-fat kind)?

- 1 time or less 2-3 times 4 or more times

76. How much margarine, butter, or meat fat do you use to season vegetables or put on potatoes, bread, or corn

- 5 or more 3-4 servings 2 or less

Part 13: Depression Scale

Over the last 2 weeks, how often have you been bothered by any of the following problems?

77. Little interest or pleasure in doing things

Not at all Several days More than half the days Nearly every day

78. Feeling down, depressed, or hopeless

Not at all Several days More than half the days Nearly every day

79. Trouble falling or staying asleep, or sleeping too much

Not at all Several days More than half the days Nearly every day

80. Feeling tired or having little energy

Not at all Several days More than half the days Nearly every day

81. Poor appetite or overeating

Not at all Several days More than half the days Nearly every day

82. Feeling bad about yourself—or that you are a failure or let yourself or your family down

Not at all Several days More than half the days Nearly every day

83. Trouble concentrating on things, such as reading the newspaper, watching TV

Not at all Several days More than half the days Nearly every day

84. Moving or speaking so slowly that other people could have noticed—or being so fidgety or restless that you have been moving around a lot more than usual

Not at all Several days More than half the days Nearly every day

Part 14: Health Literacy

Many people have difficulty reading and filling out forms when they go for medical care. The next set of questions will ask you about paperwork and information that you receive from your doctor.

85. How often do you have problems learning about medical conditions because of difficulty understanding written information?

- Always Often Sometimes Rarely Never

86. How often do you have someone like a family member, hospital worker, clinic worker, or caregiver help you read hospital materials?

- Always Often Sometimes Rarely Never

87. How confident are you filling out health care forms by yourself?

- Not confident at all Not very confident Somewhat confident Confident Extremely confident