UNIVERSITY OF CAMBRIDGE

Participant Study No.

Date

Participant sticker

The ADDITION Study:
a *study about screening for diabetes*

ISRCTN No. 99175498

One Year General Questionnaire

ADMINISTERED

Please try to answer all the questions

If you have any queries, please ask one of the staff

Your answers will be treated as confidential and will only be used for medical research

This study is supported by the Wellcome Trust, Medical Research Council, NHS Research and Development

Section A. General questionnaire.

A1. Are you taking any tablets or medicines at the moment? Yes [ ] No [ ]

A2. What are they and what are they for?

Name	Dose	No. times taken/day	Time taken (24hr clock)	Reason
Eg. Metformin	500mg	3	7.00, 13.00, 19.00	Control blood glucose

Are you taking regular vitamins ? Yes [ ] No [ ]

If yes..... *which one?* _____

A3. During the course of last year, on average how many times a week did you eat the following foods?

Food Type	Times/week	Portion size
Vegetables (not including potatoes)	☐☐	medium serving
Salads	☐☐	medium serving
Fruit and fruit products (not including fruit juice)	☐☐	medium serving or 1
fruit	☐☐	
Fish and fish products		medium serving
Meat, meat products and meat dishes (including bacon, ham and chicken)	☐☐	medium serving

A4. Have you taken any vitamins, minerals, fish oils, fibre or other food supplements during the past year?
If yes, please complete the table below. If you have taken more than 5 types of supplement please put the most frequently consumed brands first.

Vitamin supplements	**Average frequency** Tick **one** box per line to show how often on average you consumed supplements									
Name and Brand Please list full name, **Brand** and strength	**Dose** Please State Number of pills, capsules or Teaspoons consumed	Never Or less than once a month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
_____ _____										
_____ _____										
_____ _____										
_____ _____										
_____ _____										
_____ _____										

FFQ:Ely/PQ3/1001

For women only

A5. Are you on a special diet at the moment? Yes [ ] No [ ]
If yes..... What type of diet is it?

Is there any special reason why you are on it?
Please specify

A6. Has a doctor ever told you that you have any of the following?

	Yes	No	Age first Diagnosed	If treated in which hospital
High blood cholesterol (hyperlipidaemia)	[ ]	[ ]	[ ]yrs	[ ]
High blood pressure (hypertension)	[ ]	[ ]	[ ]yrs	[ ]
Angina	[ ]	[ ]	[ ]yrs	[ ]
Heart Attack (myocardial infarction)	[ ]	[ ]	[ ]yrs	[ ]
Stroke	[ ]	[ ]	[ ]yrs	[ ]
Cardiac arrhythmia/ palpitations/ irregular heartbeat	[ ]	[ ]	[ ]yrs	[ ]

Please give details……

Have you ever had an operation for coronary arteriosclerosis (balloon dilation of the coronary arteries or by-graft)?

Yes [ ] No [ ]

Section B Alcoholic drinks and smoking.

Smoking

B1. Do you smoke?

Yes, daily [ ]

Yes, occasionally (less than one cigarette, cigar or pipe a day) [ ]

No, I have never smoked [ ]

No, but previously I was a smoker. I quit in – year [ ][ ][ ][ ]

If your answer is No, please go to B2

If **Yes**

B1b. How much do you smoke a day on average?

No. cigarettes a day [ ]

No. cheroots a day [ ]

No. cigars a day [ ]

No. grams tobacco in a week [ ]

Alcoholic Drinks

B2. How many units of alcohol do you consume in an average week?

1 unit is equivalent to: ½ pint of beer
1 glass of wine
1 single measure of spirits

Units per week

Beer _____

Wine _____

Spirits _____

Section C

Please take a few minutes to answer the questions below about the feeling in your legs and feet. Tick box for yes or no based on how you usually feel.

		No	Yes
1.	Are your legs and /or feet numb?	☐	☐
2.	Do you ever have any burning pain in your legs and/or feet?	☐	☐
3.	Are your feet sensitive to touch?	☐	☐
4.	Do you get muscle cramps in your legs and/or feet?	☐	☐
5.	Do you ever have any prickling feelings in your legs or feet?	☐	☐
6.	Does it hurt when the bedcovers touch your skin?	☐	☐
7.	When you get into the tub or shower, are you able to tell the hot water from the cold water?	☐	☐
8.	Have you ever had an open sore on your foot?	☐	☐
9.	Has your doctor ever told you that you have diabetic neuropathy?	☐	☐
10.	Do you feel weak all over most of the time?	☐	☐
11.	Are your symptoms worse at night?	☐	☐
12.	Do your legs hurt when you walk?	☐	☐
13.	Are you able to sense your feet when you walk?	☐	☐
14.	Is the skin on your feet so dry that it cracks open?	☐	☐
15.	Have you ever had an amputation?	☐	☐

Total _____/15pts

Michigan Neuropathy Questionnaire (adapted)

Section D

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives.

The questions are about the time you spend being physically active in the last 7 days. They include questions about activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

Your answers are important. Please answer each question even if you do not consider yourself to be an active person.

In answering the following questions,

- **vigorous** physical activities refer to activities that take hard physical effort and make you breathe much harder that normal.
- **moderate** activities refer to activities that take moderate physical effort and make you breathe somewhat harder that normal.

1a During the last 7 days, on how many days did you do **vigorous** physical activities like heavy lifting, digging, aerobics, or fast bicycling,? Think about *only* those physical activities that you did for at least 10 minutes at a time.

_____ days per week

☐ None *(Go to question 2a.)*

1b How much time in total did you usually spend on one of those days doing vigorous physical activities*?*

____ hours ___ minutes

2a Again, think *only* about those physical activities that you did for at least 10 minutes at a time. During the last 7 days, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

_____ days per week

☐ None *(Go to question 3a.)*

2b How much time in total did you usually spend on one of those days doing moderate physical activities*?*

____ hours ___ minutes

3a During the last 7 days, on how many days did you **walk** for at least 10 minutes at a time? This includes walking at work and at home, walking to travel from place to place, and any other walking that you did solely for recreation, sport, exercise or leisure.

_____ days per week

☐ None *(Go to question 4.)*

3b How much time in total did you usually spend walking on one of those days*?*

____ hours ___ minutes

4 The last question is about the time you spent sitting on weekdays while at work, at home, while doing course work and during leisure time. This includes time spent sitting at a desk, visiting friends, reading travelling on a bus or sitting or lying down to watch television.

During the last 7 days, how much time in total did you usually spend *sitting* on a **week day?**

____ hours ___ minutes

IPAQ: Last 7 days, Short Instrument, Self-Administered Format

Section E EuroQol

Please indicate which statements best describe your health state, today, by marking one box in each group with a cross like this: [X]

1 MOBILITY

I have no problems in walking about ☐

I have some problems in walking about ☐

I am confined to bed ☐

2 SELF CARE

I have no problems with self-care ☐

I have some problems washing and dressing myself ☐

I am unable to wash or dress myself ☐

3 USUAL ACTIVITIES

(eg work, study, housework, family or leisure activities)

I have no problems with performing my usual activities ☐

I have some problems with performing my usual activities ☐

I am unable to perform my usual activities ☐

4 PAIN/DISCOMFORT

I have no pain or discomfort ☐

I have moderate pain or discomfort ☐

I have extreme pain or discomfort ☐

5 ANXIETY/DEPRESSION

I am not anxious or depressed ☐

I am moderately anxious or depressed ☐

I am extremely anxious or depressed ☐

Section F

Self Evaluation Questionnaire

A number of statements which people have used to describe themselves are given below. Read each statement and then circle the most appropriate number to the right to indicate how you feel right now, at this moment.

There are no right or wrong answers. Do not spend too much time on any one statement but give the answer which seems to describe your present feelings best.

	Not at all	Somewhat	Moderately	Very much
I feel calm	1	2	3	4
I am tense	1	2	3	4
I feel upset	1	2	3	4
I am relaxed	1	2	3	4
I feel content	1	2	3	4
I am worried	1	2	3	4

Please make sure you answer all the questions.

Speilberger Anxiety2.doc

Section G

YOUR VIEWS ABOUT CHECKING YOUR BLOOD SUGAR

- We would like you to tell us your views about checking your blood sugar at home.

- Overleaf is a list of statements that other people have made about checking their blood sugar.

- Please show how much you agree or disagree with these statements by ticking the appropriate box.

There are no right or wrong answers.
We are interested in your personal views.

Blood glucose self-monitoring questionnaire (DiGEM)

Checking Your Blood Sugar

Some people check their blood sugar at home. We would like your views on this.

G1a Please start by indicating whether you check your blood sugar at home at least twice a week.

Please circle the appropriate answer **Yes / No**

If you answered 'no' to the above question, please answer only items G1-7.

Please tick one box for each statement and answer every statement.

	VIEWS ABOUT CHECKING YOUR BLOOD SUGAR	STRONGLY DISAGREE [1]	DISAGREE [2]	NEITHER AGREE NOR DISAGREE [3]	AGREE [4]	STRONGLY AGREE [5]
G1	Checking my blood sugar at home would cause me to worry					
G2	I prefer if my health professional checks my blood sugar					
G3	Other people with diabetes can tell if their blood sugar is abnormal without testing it					
G4	I can tell if my blood sugar is abnormal without testing it					
G5	Checking my blood sugar is not important					
G6	I do not check my blood sugar because it is painful					
G7	I do not think I need to check my blood sugar more than once a week					

If you **do not** check your blood sugar at home **at least twice a week**, there is no need to complete any more questions. Thank you for your time.

If you check your blood sugar at home **at least twice a week**, please complete the remaining questions on the following page……..

	VIEWS ABOUT CHECKING YOUR BLOOD SUGAR	STRONGLY DISAGREE [1]	DISAGREE [2]	NEITHER AGREE NOR DISAGREE [3]	AGREE [4]	STRONGLY AGREE [5]
G8	I check my blood sugar at home because my health professional recommended it					
G9	I check my blood sugar at home because I am curious to see what the results are					
G10	I check my blood sugar according to a routine					
G11	Checking my blood sugar helps me to control my eating habits					
G12	I check my blood sugar after a big meal to see if it has gone up					
G13	I check my blood sugar if I am not feeling well					
G14	If my blood sugar were high, I would eat less at my next meal					
G15	If my blood sugar were high, I would recheck it later					
G16	If my blood sugar were high, I would try to figure out what I had done to cause it to increase					
G17	I would not do anything differently if my blood sugar were high					
G18	If my blood sugar were persistently high, I would see my health professional					
G19	If my blood sugar were low and I was feeling well, I would not do anything					
G20	If my blood sugar were low and I was feeling unwell, I would have something to eat					
G21	If my blood sugar were persistently low, I would see my health professional					
G22	Checking my blood sugar at home alerts me early if there's a problem with my blood sugar control					
G23	Checking my blood sugar reassures me					

Blood glucose self-monitoring questionnaire (DiGEM)

THANK YOU FOR TAKING THE TIME TO ANSWER THESE QUESTIONS