Apollo Sugar® Clinics

First Visit Questionnaire:

1. Are you aware of which type of diabetes you have?
    a. Yes b No

2. Is there anyone in the family with diabetes?
    a. Yes b. No

3. Do you know about diabetes, what happens and how it occurs?
    a. Yes b. No c. Not much

4. Do you know or heard about the complications and factors that are associated with diabetes?
    a. Yes b. No d. Very little information

5. Do you have any past history of
    a. Hypertension b. Abnormal lipid profile c. Cardiovascular/Heart disease d. Kidney issues e. Neuropathy/Foot problems f. Retinopathy/Eye problems g. Smoking

6. Are you initiated with insulin treatment? If yes, have you received enough information on how to take insulin?
    a. Yes b. No c. Not much information

7. Do you know about hypoglycemia?
    a. Yes b. No

8. Would you like to know about how to manage diabetes with diet, exercise, treatment regimen and self-management?

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Follow Up Visit Questionnaire:

1. How are you coping with self-care and self-management of diabetes a. Good
   b. Better c. bad
2. Are you informed about how to manage your diet?
   a. Yes b. No

3. Would you like to receive educational inputs on dietetics, exercise, insulin regimen, treatment adherence to improve your understanding of the condition and self-management?
   a. Yes b. No c. don't know

4. Are you still smoking? If yes, what help do you need to stop smoking?

5. Were you hospitalized for any of the below complications
   a. Hypoglycemia b. diabetic ketoacidosis c. hyperglycemic state

6. In the past have you experienced symptoms associated with any of the below complications
   a. Cardiovascular b. Renal c. Eye d. Nerve e. Foot

7. How are you coping with and complying with a diabetes medication regimen?
a. Tight adherence to medication pattern b. Monitoring the dose adjustments when required

8. Are you on Insulin? If yes, do you face any problem with the injection of insulin?
   a. Yes b. No c. not really

9. Do you have any problem with the timing of insulin or oral medications?
   a. Yes b. No

10. Do you miss your medication regularly? Yes/No. If yes, how frequently?
    a. Weekly once b. Monthly once c. At least once a day

11. Do you monitor your blood glucose regularly using a glucose monitoring device?
    a. Yes b. No

12. Do you maintain a record of your glucose readings?
    a. Yes b. No