Questionnaire

Date: Patient No.: _____

1. Sex: Male Female
2. Age: _____
3. What is your literacy level?
   Able to read and write in Chinese
   Unable to read and write in Chinese
4. How long had you had diabetes for?
   Up to 10 years
   10-15 years
   ≥15 years
5. How do you control your diabetes?
   Using non-insulin treatment (Diet only/tablets/or both combined)
   Using insulin treatment (insulin only or combining insulin with tablet or diet)
6. Do you think your diabetes is controlled?
   Yes
   No
   Not sure
7. Do you think exercise is important to control diabetes?
   Yes
   No
   Not sure
8. How many hours a week do you exercise such as cycling, swimming, jogging, and hiking?
   <4 hours
   ≥4 hours
9. Does diabetes restrict your everyday activities?
   Yes
   No
   Not sure
10. Can diabetes affect eyes?
    Yes
    No
    Not sure
11. Have you attended diabetic eye examination previously?

Yes

No

Not sure

12. Have you had any treatment in the eye other than glasses (like surgery, LASER) as a result of diabetes?

Yes

No

Not sure

13. How many times in the last year did you have to seek urgent medical help from hospital/doctor/nurse because your blood sugar was not controlled?

None

1-10 times

≥10 times

14. Do you take alcohol?

Yes

No

15. Do you smoke?

Yes

No

16. How often do you check your blood sugar?

At least once a month

From once a month to once within a year

17. How often in the last year did you forget to inject or take medicine?

0 times

1-5 times

≥5 times