

**HAT Study**  
**Patient Self-Assessment Questionnaire & Diary**

# Part 1

## **PART 1 OF 2**

### **THIS SECTION IS TO BE COMPLETED TODAY**

#### **Q1**

Have you received insulin for more than 12 months?

Yes (***Please proceed to Q2***)

No (***If you have answered no, then you do not need to complete the rest of the questionnaire.***)

The questionnaire was designed to look at hypoglycaemia occurring while on insulin therapy. We are sorry to have disturbed you)

#### **Q2**

How old are you?  
\_\_\_\_\_ years old

#### **Q3**

Are you male/female?

Male

Female

#### **Q4**

What type of diabetes do you have? (Cross one)

Type 1

Type 2

Not sure

Other

#### **Q5**

How long have you had diabetes?  
\_\_\_\_\_ years

#### **Q6**

How long have you been using insulin?  
\_\_\_\_\_ years

#### **Q7**

What was the last measured HbA1c value?

Date of measurement:

Result: \_\_\_\_\_ % **OR** \_\_\_\_\_ mmol/mol

Not sure

#### **Q8**

What do you use to treat your diabetes? (Cross all that apply)

Short-acting insulin

Long-acting insulin

Mixed insulin

Insulin pump

Oral anti-diabetes treatments (i.e. tablets)

Injectable anti-diabetes treatments other than insulin (e.g. Victoza, Byetta)

**Q9**

Do you use a Continuous Glucose Monitoring (CGM) device?

- Yes  
 No  
 Not sure

**Q10**

Do you check your blood sugar levels?

- Yes (*Proceed to Q11*)  
 No (*Proceed to Q12*)

**Q11**

How many times a day do you check your blood sugar on average?  
times a day

**Q12**

Did you know what hypoglycaemia was, before you read the definition provided in the introduction to this survey?

- Yes  
 No

**Q13**

Have you ever experienced hypoglycaemia?

- Yes (*Proceed to Q14*)  
 No (*Proceed to Q18*)  
 Not sure (*Proceed to Q18*)

**Q14**

How do you know when you have a hypoglycaemic event? (Cross one)

- I have symptoms of hypoglycaemia  
 My measured blood sugar level is low  
 Either symptoms or a low blood sugar measurement  
 Both symptoms and a low blood sugar measurement  
 Other – please specify:

**Q15**

If you have used blood sugar measurements to determine whether you have hypoglycaemia, please enter the blood sugar level below which you consider to be a hypoglycaemic event

Reading:                      mmol/l                      **OR**                      mg/dl

- Not applicable  
 Not sure

**Q16**

Do you have symptoms when you have a low blood sugar measurement?

- Always  
 Usually  
 Occasionally  
 Never

**Q17**

Have you ever lost consciousness as a result of hypoglycaemia?

- Yes  
 No  
 Not sure

**Q18**

On a scale from 0-10, how afraid are you of hypoglycaemia? (Circle relevant number below)

0 = Not afraid at all

10 = Absolutely terrified

0	1	2	3	4	5	6	7	8	9	10
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### Q19

Have you done any of the following because of your fear of hypoglycaemia?

a. consulted your doctor/nurse?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
b. increased the quantity of sugar or number of snacks in your diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
c. reduced the amount of sport or physical exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
d. decreased your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
e. skipped your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
f. increased the number of times you check your blood sugar?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

### Q20

In the last **6 months**, have you had hypoglycaemia which:

a. resulted in hospital admission	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes: How many times have you been admitted to hospital?  In total, how many days were you in hospital?
b. required assistance from medical personnel but not requiring hospital admission	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
c. required assistance from another person to actively administer carbohydrate, glucagon, or other resuscitative actions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?

In the last **4 weeks**, have you had hypoglycaemia which:

d. required assistance from another person to actively administer carbohydrate, glucagon, or other resuscitative actions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
e. you managed by yourself	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
f. occurred at night between the hours of midnight and 6 am	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?

***If you responded 'yes' to any of the above, proceed to Q21.***

***If you responded 'no' to all the above, proceed to Q24.***

### Q21

If you have had a hypoglycaemic event in the last 6 months, in which circumstances did it occur?

(Cross all that apply)

- At night
- At work
- While conducting sports / physical activities
- While driving
- While eating
- While sleeping

- During leisure time (watching TV, relaxing ....)
- Other, please specify

### Q22

If you have had a hypoglycaemic event in the last 6 months, please cross any of the following actions that apply:

- The hypoglycaemic event was addressed at my next scheduled clinic visit
- I made extra clinic appointments with my doctor/nurse – please specify how many \_\_\_\_\_
- I rescheduled my clinic appointment for an earlier time
- I discussed the hypoglycaemic event with my doctor/nurse over the telephone – please specify how many times \_\_\_\_\_
- I consulted another health worker – please specify
- I did not consult a doctor/nurse/health worker
- Not applicable

### Q23

As a result of hypoglycaemia over the last 6 months, have you:

a. increased the quantity of sugar or number of snacks in your diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
b. reduced the amount of sport or physical exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
c. decreased your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
d. skipped your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many times? time(s)
e. increased the number of times you check your blood sugar per day?	<input type="checkbox"/> No	<input type="checkbox"/> 1 extra test <input type="checkbox"/> 2 extra tests <input type="checkbox"/> 3+ extra tests	If yes, on how many days? day(s)
f. made any other changes to your diabetes treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

**Proceed to Q25**

### Q24

If you answered “No” to Q20 above, is it because:

a. you avoid hypoglycaemic events because you are in control of your diabetes?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure
b. you test your blood sugar levels frequently and therefore manage to correct low sugar levels before you become hypoglycaemic?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure
c. you deliberately keep your blood sugar levels high to reduce the risk of hypoglycaemic events?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure
d. you don't really know what a hypoglycaemic event is and therefore you are not sure if you have experienced this?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Not sure
e. other reason?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Specify:

### Q25

Which of the following statements most accurately describes your employment status

- Student (**Proceed to Q26**)
- Full-time employment (**Proceed to Q26**)

Part-time employment (*Proceed to Q26*)

Unemployed (*Proceed to Q27*)

Pensioned (*Proceed to Q27*)

Other - Please specify:

(*Proceed to Q27*)

### Q26

As a result of hypoglycaemia, have you ever:

a. taken sick leave from your work or studies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many days in the last year do you think you have taken off as a result of hypoglycaemia? day(s)
b. gone to your work or studies late?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many days in the last year do you think you have been late as a result of hypoglycaemia? day(s)
c. left your work or studies early?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many days in the last year do you think you have left work early as a result of hypoglycaemia? day(s)

### Q27

Do you currently hold a full drivers license?

Yes (*Proceed to Q28*)

No (*Proceed to Q29*)

### Q28

Have you ever experienced a hypoglycaemic event whilst driving?

Yes

No

### Q29

Please indicate for each of the five statements below, which response is closest to how you have been feeling over the last **two** weeks.

*Notice that higher numbers mean better well-being.*

*Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a circle around the number 3. Only circle **one** number in each row.*

Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	5	4	3	2	1	0
I have felt calm and relaxed	5	4	3	2	1	0
I have felt active and vigorous	5	4	3	2	1	0

I woke up feeling fresh and rested	5	4	3	2	1	0
My daily life has been filled with things that interest me	5	4	3	2	1	0
<b>PLEASE HAND THE COMPLETED SECTION TO YOUR DOCTOR/NURSE</b>						

# Part 2

## PART 2 OF 2

### THIS SECTION LOOKS AT THE NEXT 4 WEEKS:

To further increase our knowledge about hypoglycaemia, we would like to ask you to summarise your experience of hypoglycaemia at home over the course of the next 4 weeks. To help you track your experiences, we would like you to fill in the attached diary.

**At the end of the 4 weeks, please answer the following questions. Please answer every question using black or blue pen and remember there are no right or wrong answers to these questions. For the Yes / No questions, please place a cross in the appropriate box.**

Once you have completed the questionnaire and diary, please return them to us using the enclosed pre-paid envelope.

Thank you very much for participating in this survey and helping us further our knowledge about diabetes.

### Q1

In the last **4 weeks**, have you had hypoglycaemia which:

a. resulted in hospital admission	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes: How many times have you been admitted to hospital? In total, how many days were you in hospital?
b. required assistance from medical personnel but not requiring hospital admission	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
c. required assistance from another person to actively administer carbohydrate, glucagon, or other resuscitative actions	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
d. you managed by yourself	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?
e. occurred at night between the hours of midnight and 6 am	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many episodes have you had?

**If you responded 'yes' to any of the above, proceed to Q2.**

**If you responded 'no' to all the above, proceed to Q5.**

### Q2

If you have had a hypoglycaemic event in the last 4 weeks, please cross any of the following actions that apply:

- The hypoglycaemic event was addressed at my next scheduled clinic visit
- I made extra clinic appointments with my doctor/nurse – please specify how many
- I rescheduled my clinic appointment for an earlier time
- I discussed the hypoglycaemic event with my doctor/nurse over the telephone – please specify how

many times

- I consulted another health worker – please specify
- I did not consult a doctor/nurse/health worker
- Not applicable

### Q3

As a result of hypoglycaemia over the last 4 weeks, have you:

a. taken sick leave from work or studies?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
b. gone to your work or studies late?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
c. left your work or studies early?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)

### Q4

As a result of hypoglycaemia over the last 4 weeks, have you:

a. increased the quantity of sugar or number of snacks in your diet?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
b. reduced the amount of sport or physical exercise?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
c. decreased your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, on how many days? day(s)
d. skipped your insulin dose?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, how many times? time(s)
e. increased the number of times you check your blood sugar per day?	<input type="checkbox"/> No	<input type="checkbox"/> 1 extra <input type="checkbox"/> 2 extra <input type="checkbox"/> 3+ extra	If yes, on how many days? day(s)
f. made any other changes to your diabetes treatment?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	

### Q5

Please indicate for each of the five statements below, which response is closest to how you have been feeling over the last **two** weeks.

*Notice that higher numbers mean better well-being.*

*Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a circle around the number 3. Only circle **one** number in each row.*

Over the last two weeks	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	5	4	3	2	1	0
I have felt calm and relaxed	5	4	3	2	1	0

I have felt active and vigorous	5	4	3	2	1	0
I woke up feeling fresh and rested	5	4	3	2	1	0
My daily life has been filled with things that interest me	5	4	3	2	1	0

**PLEASE POST THIS COMPLETED FORM AND DIARY USING THE PRE-PAID ADDRESSED ENVELOPE.**

# Diary

**Below is a calendar covering the next 4 weeks from today (DAY 1). If you have a hypoglycaemic event ('HYPO'), then please answer the questions underneath the relevant day. If you had more than one HYPO on any given day, then please answer the questions for the most severe HYPO.**

	EXAMPLE	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
Did you have a HYPO?	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following
How many HYPOs have you had?	1							
Did you have any symptoms?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What time did the HYPO occur?	4 am							
What was the blood sugar level?	2.9	mmol/l OR mg/dl	mmol/l OR mg/dl	mmol/l OR mg/dl	mmol/l OR mg/dl	mmol/l OR mg/dl	mmol/l OR mg/dl	mmol/l OR mg/dl
Did you need any assistance from another person?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person
Did you lose consciousness as a result of the HYPO?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What were you doing when the HYPO occurred?	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input checked="" type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other
Did you take time off work because of the HYPO?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Did you speak to your doctor or nurse because of the HYPO? If yes, enter number of times	<input checked="" type="checkbox"/> Yes times <input type="checkbox"/> No	<input type="checkbox"/> Yes times <input type="checkbox"/> No						

	DAY 8	DAY 9	DAY 10	DAY 11	DAY 12	DAY 13	DAY 14
Did you have a HYPO?	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following
How many HYPOs have you had?							
Did you have any symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What time did the HYPO occur?							
What was the blood sugar level?	mmol/l OR mg/dl						
Did you need any assistance from another person?	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person
Did you lose consciousness as a result of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What were you doing when the HYPO occurred?	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other
Did you take time off work because of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Did you speak to your doctor or nurse because of the HYPO? If yes, enter number of times	<input type="checkbox"/> Yes times <input type="checkbox"/> No						

	DAY 15	DAY 16	DAY 17	DAY 18	DAY 19	DAY 20	DAY 21
Did you have a HYPO?	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following
How many HYPOs have you had?							
Did you have any symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What time did the HYPO occur?							
What was the blood sugar level?	mmol/l OR mg/dl						
Did you need any assistance from another person?	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person
Did you lose consciousness as a result of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What were you doing when the HYPO occurred?	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other
Did you take time off work because of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Did you speak to your doctor or nurse because of the HYPO? If yes, enter number of times	<input type="checkbox"/> Yes times <input type="checkbox"/> No						

	DAY 22	DAY 23	DAY 24	DAY 25	DAY 26	DAY 27	DAY 28
Did you have a HYPO?	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following	If you had a HYPO today then answer the following
How many HYPOs have you had?							
Did you have any symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What time did the HYPO occur?							
What was the blood sugar level?	mmol/l OR mg/dl						
Did you need any assistance from another person?	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person	<input type="checkbox"/> No <input type="checkbox"/> Doctor/nurse <input type="checkbox"/> Another person
Did you lose consciousness as a result of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
What were you doing when the HYPO occurred?	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other	<input type="checkbox"/> Exercise <input type="checkbox"/> Eating <input type="checkbox"/> Sleeping <input type="checkbox"/> Relaxing <input type="checkbox"/> Driving <input type="checkbox"/> Other
Did you take time off work because of the HYPO?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Did you speak to your doctor or nurse because of the HYPO? If yes, enter number of times	<input type="checkbox"/> Yes times <input type="checkbox"/> No						