

Diabetes Symptom Checklist (DSC-R)

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Instructions

People with diabetes can experience various discomfoting physical and mental symptoms related to their disease. In order to know how much you are troubled by particular symptoms, we would like you to fill in this questionnaire. Please circle whether you have experienced the symptom or not in the past month, today included. If you circle “yes” then indicate to what extent the symptom listed has caused you discomfort by circling the number that most closely reflects your experience.

If a symptom did **NOT** occur, please circle “No” in the column “DID SYMPTOM OCCUR”

EXAMPLE

DID SYMPTOM OCCUR?		THE SYMPTOM DID OCCUR AND WAS TROUBLESOME TO ME				
		not at all	a little	moderately	very	extremely
Sore throat?	No					
	Yes → → → →	1	②	3	4	5

This answer means:

In the last month I did have a sore throat and it was a little troublesome to me.

How much trouble have these symptoms given you
over the last month?

	DID SYMPTOM OCCUR?	THE SYMPTOM DID OCCUR AND WAS TROUBLESOME TO ME				
		not at all	a little	moderately	very	extremely
1. Lack of energy?	No Yes → → → →	1	2	3	4	5
2. Aching calves when walking?	No Yes → → → →	1	2	3	4	5
3. Numbness (loss of sensation) in the feet?	No Yes → → → →	1	2	3	4	5
4. An overall sense of fatigue?	No Yes → → → →	1	2	3	4	5
5. Shortness of breath at night?	No Yes → → → →	1	2	3	4	5
6. Sleepiness or drowsiness?	No Yes → → → →	1	2	3	4	5
7. Difficulty concentrating?	No Yes → → → →	1	2	3	4	5
8. Moodiness?	No Yes → → → →	1	2	3	4	5
9. Numbness (loss of sensation) in the hands?	No Yes → → → →	1	2	3	4	5
10. Persistently blurred vision (even with glasses on)?	No Yes → → → →	1	2	3	4	5

How much trouble have these symptoms given you
over the last month?

	DID SYMPTOM OCCUR?	THE SYMPTOM DID OCCUR AND WAS TROUBLESOME TO ME				
		not at all	a little	moderately	very	extremely
11. Tingling sensations in the limbs at night?	No Yes → → → →	1	2	3	4	5
12. Very thirsty?	No Yes → → → →	1	2	3	4	5
13. Palpitations or pounding in the heart region?	No Yes → → → →	1	2	3	4	5
14. Deteriorating vision?	No Yes → → → →	1	2	3	4	5
15. Burning pain in the calves at night?	No Yes → → → →	1	2	3	4	5
16. Dry mouth?	No Yes → → → →	1	2	3	4	5
17. Increasing fatigue during the course of the day?	No Yes → → → →	1	2	3	4	5
18. Flashes or black spots in the field of vision?	No Yes → → → →	1	2	3	4	5
19. Irritability just before a meal?	No Yes → → → →	1	2	3	4	5
20. Fatigue in the morning when getting up?	No Yes → → → →	1	2	3	4	5

How much trouble have these symptoms given you
over the last month?

		THE SYMPTOM DID OCCUR AND WAS TROUBLESOME TO ME				
		not at all	a little	moderately	very	extremely
21. Shooting pains in the legs?	No					
	Yes → → → →	1	2	3	4	5
22. Alternating clear and blurred vision?	No					
	Yes → → → →	1	2	3	4	5
23. Frequent need to empty your bladder?	No					
	Yes → → → →	1	2	3	4	5
24. Pains in the chest or heart region?	No					
	Yes → → → →	1	2	3	4	5
25. Burning pain in the legs during the day?	No					
	Yes → → → →	1	2	3	4	5
26. Tingling or prickling sensations in the hands or fingers?	No					
	Yes → → → →	1	2	3	4	5
27. Easily irritated or annoyed?	No					
	Yes → → → →	1	2	3	4	5
28. Sudden deterioration of vision?	No					
	Yes → → → →	1	2	3	4	5
29. Odd feeling in the (lower) legs or feet when touched?	No					
	Yes → → → →	1	2	3	4	5

How much trouble have these symptoms given you
over the last month?

		DID SYMPTOM OCCUR?	THE SYMPTOM DID OCCUR AND WAS TROUBLESOME TO ME				
			not at all	a little	moderately	very	extremely
30. Shortness of breath during physical exertion?	No	Yes → → → →	1	2	3	4	5
31. Fuzzy feeling in your head (difficulty thinking clearly)?	No	Yes → → → →	1	2	3	4	5
32. Drinking a lot (all sorts of beverages)?	No	Yes → → → →	1	2	3	4	5
33. Difficulty paying attention?	No	Yes → → → →	1	2	3	4	5
34. Tingling or prickling sensations in the lower legs or feet?	No	Yes → → → →	1	2	3	4	5
Any other symptoms:							
35.	Yes	→ → → →	1	2	3	4	5
36.	Yes	→ → → →	1	2	3	4	5
37.	Yes	→ → → →	1	2	3	4	5

Please check that you have answered **all** of the questions.

Scoring of the Diabetes Symptom Checklist, DSC-r

Psychology, fatigue: $(dscr1+dscr4+dscr17+dscr20)/4$.

Psychology, cognitive: $(dscr6+dscr7+dscr31+dscr33)/4$.

Neurology, pain: $(dscr2+dscr15+dscr21+dscr25)/4$.

Neurology, sensory: $(dscr3+dscr9+dscr11+dscr26+dscr29+dscr34)/6$.

Cardiology: $(dscr5+dscr13+dscr24+dscr30)/4$.

Ophthalmology: $(dscr10+dscr14+dscr18+dscr22+dscr28)/5$.

Hypoglycaemia: $(dscr8+dscr19+dscr27)/3$.

Hyperglycaemia: $(dscr12+dscr16+dscr23+dscr32)/4$.