Diabetes Tablet Treatment Questionnaire (status): DTTQs-7

This questionnaire is about your experience of taking tablets for your diabetes over the past few weeks.

1. Please describe in the box below the recommendations for taking your diabetes tablets.

Please use BLOCK CAPITALS in all your answers:

	Name of tablet	Number taken each day	When should tablets be taken? (e.g. MORNING, WITH BREAKFAST, BEFORE FOOD, ANY TIME)
Tablet 1			
Tablet 2			
Tablet 3			
Tablet 4			
Tablet 5			

Please add any other diabetes tablets and further instructions for taking your tablets

Next, please answer each question below, by circling a number from 0 – 6 on each scale.

2. How often have you taken your diabetes tablets exactly as recommended?

all of the time 6 5 4 3 2 1 0 none of the time

3. How often do you find it inconvenient or difficult to take your tablets as recommended?

none of the time 0 1 2 3 4 5 6 all of the time

For information only

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