



Addressograph here

PATIENT CLINIC QUESTIONNAIRE (NON-PUMP)

Date:	Who is completing this form today?
What would you like to discuss today?	
Name of family doctor/pediatrician:	
Date of last eye exam?	School grade?
Any allergies? If so, please describe:	
List all current activities in which your child participates:	

List all non diabetes medication , including, prescribed medications, multivitamins, herbal supplements.
Medication Name/Dose and Frequency

List your child's insulin dose .		
<i>Meal</i>	<i>Insulin: type/dose/Insulin carb ratio if using</i>	<i>ISF, correction factor or sliding scale</i>
<i>Breakfast</i>		
<i>Snack</i>		
<i>Lunch</i>		
<i>Snack</i>		
<i>Dinner</i>		
<i>Snack</i>		
<i>Bedtime</i>		

What are your carb goals, or carb range at meals and snacks?					
<i>Breakfast</i>	<i>a.m. snack</i>	<i>Lunch</i>	<i>p.m. snack</i>	<i>Supper</i>	<i>Bedtime</i>

<i>Insulin</i>	<i>Always</i>	<i>Often</i>	<i>Sometimes</i>	<i>Never</i>
Does your child give his/her own insulin ?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is insulin given <u>before</u> meals?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Which sites are you using?	<input type="checkbox"/> Arms	<input type="checkbox"/> Legs	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Tummy

Who is most responsible for:	Shared	Parent	Child	Nobody
• Preparing food?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating carb at meals/snacks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating insulin dose for carb eaten?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• calculating correction dose for high blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What tools do you use to calculate carb content of foods?

Food labels
 Measuring Cups
 Binder from diabetes clinic
 Other:

Scales
 "Eyeball"
 Carb-counting books/software/apps

Since your child's <u>last diabetes clinic</u> visit, has she/he had:	No	Yes
• any visit(s) to the hospital?	<input type="checkbox"/>	<input type="checkbox"/>
• high blood sugars with ketones?	<input type="checkbox"/>	<input type="checkbox"/>
• a low blood sugar with confusion, loss of consciousness or seizure?	<input type="checkbox"/>	<input type="checkbox"/>

On average, how many lows per week?

How do you treat low blood sugar? (with how many grams of carb?)

	Always	Often	Sometimes	Never
Does your child wear a medic alert?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your child recognize low blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you or your child carry low treatments?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When would you test for ketones?	<input type="checkbox"/> During Illness <input type="checkbox"/> When blood sugar is greater than 14 <input type="checkbox"/> Never			
Do you have up-to-date ketone testing strips?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
Do you have an up-to-date Glucagon Kit?	<input type="checkbox"/> Yes	<input type="checkbox"/> Don't Know	<input type="checkbox"/> No	
Do you need a prescription renewal?	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes	

Does your child have:	No	Somewhat	Yes
• issues with insulin injections or finger pokes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• a fear of low blood sugars?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• anxiety or depression?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• concerns about body weight and/or appearance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there family events/issues that are impacting diabetes management ?
 No
 Yes: If yes, describe:

We routinely ask all families about domestic violence. Domestic violence can include physical abuse, but also can include sexual, emotional or spiritual abuse, controlling or threatening behavior, financial misuse and control, or neglect.

Is this a problem for you?
 No
 Yes

Reviewed by: _____



Alberta Children's Hospital Diabetes Clinic

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Diabetes Clinic
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Dear Parent,

In order to assess your eating habits, it is most helpful to fill out a three (3) day food record, which tracks what you eat, how much you eat and when you ate it.

- You may need to measure or weigh some portions to determine more accurate portion sizes.
- Eat as you normally would while keeping your food records.
- Remember to complete the food record prior to Diabetes clinic appointment with the Dietitian. You can either email the food diary or bring it with you to your appointment.

Instructions: To complete the Food Diary follow these instructions and the example below.

1. **Record** usual time of meal, carbohydrate goals, insulin/carb ratio (if used) and usual insulin dose in left-hand column.
2. **Record** blood glucose test results (BG) in upper left-hand boxes.
3. **Record** food intake for 3 days. Specify types and amounts (weight or volume) and **the carbohydrate count of all foods eaten**. To record ACTUAL food intake:
 - ✓ Indicate the **amount** and **kind of food** eaten in weight or cups using imperial or metric measurements, e.g. 50g (weight) Kellogg's Rice Krispies.
 - ✓ Indicate preparation method, e.g. 1/2 cup **boiled** potatoes.
 - ✓ Indicate butter fat content of dairy products, e.g. 1/2 cup **2%** milk.
 - ✓ If eating out - indicate restaurant and food eaten (be as specific as possible!), e.g. 1/8th of 10" thin crust **Boston Pizza** - pineapple, ham and cheese.
 - ✓ Provide the recipe (including all ingredients and the yield) of homemade dishes such as casseroles or baking.
4. **Record** activity and multivitamins/herbal supplements taken at the bottom the page.

	DATE:	Carb
Breakfast Time: <u>7:30</u>	BG: <u>6.5</u>	
• Carb Goals <u>65 g</u>	2 slices of whole wheat toast	30g
	1 Tbsp Kraft peanut butter	3g
	2 tsp Smucker's Strawberry No Sugar Added Jam	4g
• Insulin/carb ratio _____	1 cup 2% milk	12g
	1 small banana (101g)	20g
• Usual Insulin <u>6H 21N</u>	TOTAL	69g

Recording your intake, bg and insulin doses helps us help you manage your diabetes.

If you have a question, please call or email.

Deanna Langille RD, CDE	Julia Mercer RD, CDE	Karen Plett RD
Registered Dietitian	Registered Dietitian	Registered Dietitian
403-955-7332 deanna.langille@ahs.ca	403-955-3253 julia.mercer@ahs.ca	403-955-2984 karen.plett@ahs.ca

	DATE	Carb	DATE	Carb	DATE	Carb
Breakfast Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: <input type="text"/>		BG: <input type="text"/>		BG: <input type="text"/>	
Snack Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____						
Lunch Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: <input type="text"/>		BG: <input type="text"/>		BG: <input type="text"/>	
Snack Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____						
Supper Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: <input type="text"/>		BG: <input type="text"/>		BG: <input type="text"/>	
Snack Time: _____ • Carb goals _____ • Insulin: carb ratio _____ and/or • Set insulin dose _____	BG: <input type="text"/>		BG: <input type="text"/>		BG: <input type="text"/>	
Activity: • Type _____ • Time _____ Multivitamins/Herbal supplements:						