Alberta Health Services

Diabetes Centre Calgary

Important Information about Appointments

Welcome to the Diabetes Centre Calgary. Please take a few minutes to read the following. It will help you get the best care while working with your health care team.

1. If you are not able to make an appointment, even if it is the same day, it is very important that you call 403-955-8146 to cancel. We have a 24 hour answering machine if you need to leave a message. We are happy to rebook an appointment. Calling us to cancel helps us accommodate urgent clients and shorten wait lists. Thank you for helping others by calling if you can't make your appointment!

2. If you are more than 15 minutes late for your appointment, you may be asked to reschedule it. Our health educators may have been booked to help other clients. Please let our clerks know if there was an unusual delay such as the use of a handibus, taxi or out of town arrivals.

3. Please plan to arrive 10 minutes early for your appointment to allow for parking, finding the office and any forms that need filling out.

4. 15 minutes of each appointment time may be set aside for communicating with your doctor. For example, if you are booked for 45 minutes you may see the educator for 30 minutes.

5. Before your visit, complete any lab work your doctor or educator has requested. Please bring your blood glucose records recorded in columns, e.g.

Date	Breakfast	Lunch	Supper	Before Bed
Monday June 6	8.9		7.1	9.0
Tues	9.1	7.0	7.6	
Wed	8.0			11.3

6. Your first visit is usually an assessment to get to know your needs. We look forward to addressing your health needs thoroughly and thoughtfully. Please share your goals for your visit with your educator. Given time constraints, we may address your urgent concerns first and offer handouts, classes, online materials or further appointments for other needs.

7. Phone call and email follow-ups may be booked at a specific date and time. If you call or email your educator on days that you don't have time scheduled, you may not hear back from the educator that day. Educators may need to get back to you on another day, when openings are available in their schedules.

8. If you have urgent diabetes needs and are not able to reach your educator immediately, please see your doctor, urgent care, emergency or call 911.

Diabetes Centre Calgary

Appointment Questionnaire

If you test your blood sugar, please
bring your blood sugar record and meter

Please fill out these forms as completely as possible.

This form becomes part of your file, and is only seen by the providers involved with your care.

Name:

Date of birth:

Doctor:

Date:

Other diabetes educators you see:

Allergies:

The **topics or questions** you would most like to discuss at this appointment are:

Is anything **getting in the way** of taking care of your health? Please list.

As far as you know, do you ever have **low blood sugars (under 4)**?
How often do they happen?
Do you carry something to **treat** low blood sugar? If so, what?
Do you feel signs when your blood sugar is low? If so, what are they?

As far as you know, do you have **high blood sugars**?
If so, what have you identified as the **cause** of the highs?
What blood sugar numbers would you like for yourself?

Do you have any wounds or cuts, or other concerns, to your **feet or legs**?
Note that your feet and legs might be examined during your visit.

Have you been told you have high blood pressure?
Have you had trouble speaking, understanding, seeing or walking, sudden weakness, or other unusual symptoms when your blood sugar was not low?
Have you had any chest discomfort that is not relieved by rest?

Other medical concerns or problems:

How tall are you?
Have you gained or lost weight recently? ☐ Gained ☐ Lost
How much?
What is your usual weight?
Goal weight:

List your **diabetes medications**, including the doses and time taken. (If you prefer, you can get a print out from your pharmacy.)

Name	Dose	Time taken

List your **other medications, supplements, vitamins and herbs**, including the doses and time taken. (If you prefer, you can get a print out from your pharmacy.)

Name	Dose	Time taken

Do you **exercise**? If so, what time of day do you exercise?

What kind of exercise do you do?

Diabetes screens and checks:

When did you last have a diabetic **eye exam**?

When did you last have your **teeth** checked?

Have you had a **pneumococcal vaccine**? ☐ Yes ☐ No ☐ Unsure
When was your last **flu vaccine**?

When did a health care professional last check your **feet**?

What language do you speak at home?

Are you able to use English to speak about your health?

Food:

Do you avoid any foods for religious or other reasons?

What foods do you avoid?

Who prepares your meals and snacks?

Who does the **grocery shopping**?

How many times in a week do you eat or drink **take out or restaurant foods**?

Please bring at least 3 days of food records to review at your appointment.

See the back of this handout for the Food Record sheet.

Thank you for your participation!

3-Day Food and Activity Journal

See the next page for instruction on how to use this food journal.

Meal	Day1:	Day2:	Day3:
Breakfast (First Meal)			
Snack			
Lunch (Second Meal)			
Snack			
Dinner (Third\Meal)			
Snack			
Activity			

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How to fill in this Journal:

☐ Write down everything you eat and drink. You may want to record one weekday (or workday) and one Saturday or Sunday (or day off).

☐ Include:

- How much food you ate. See the suggestions below to estimate portion sizes. If the food comes in a package, just write down the package size. Example: 175 ml container of yogurt.
- How the food is cooked (for example: fried, baked broiled, barbequed)
- Anything you add to food, during or after cooking. Example: cream, sugar, oil, butter, jam, syrup, ketchup or other sauces, dressings or condiments.
- Details about restaurant foods, fast foods, or packaged foods (for example: McDonald's Big Mac® or KFC® chicken).

☐ Measure the food you eat for a day or two to help you understand how much you eat and drink. Use measuring cups and spoons.

☐ Write down all your activities for the day. Include planned activities (going for a walk or swim) and activities of daily life (housework or grocery shopping). Comments may include where you ate, your mood or stress level.

☐ Use more paper if you need to or photocopy the other side of this handout.

☐ Read over your journals to see what is working well and what you may want to change.

☐ Keep on tracking. Use this tool to help you meet your goals, or to make new goals.

To estimate portion sizes, use the guidelines below:

This amount of food:	**…. is about the same size as:**
2 ½ oz. (75 g) of meat	A hockey puck
1 ½ oz. (50 g) of cheese	2 white erasers
1 cup (250 ml)	A baseball or fist
½ cup (125 ml)	A hockey puck
1 medium piece of fruit	A tennis ball
2 Tbsp. (30 ml)	1 golf ball
¼ cup (60 ml)	2 golf balls
1 Tsp. (5 ml) – use for butter, margarine, mayonnaise	A thumb tip or one die

Example of how to fill in your food journal:

Meal:	**Day 1: Thursday**	**Day 2: Saturday**
Breakfast (First Meal)	1 cup Bran Flakes® with 1 tsp sugar And ½ cup 1% milk 1 cup black coffee 1 slice whole wheat toast with two tsp soft margarine	1 fried egg in I tsp butter with 3 strips of bacon, 2 slices whole wheat toast with 2 tsp soft margarine 2 cups tea (chamomile)
Snack	1 carrot muffin – Tim Hortons® 1 medium black coffee - Tim Hortons®	1 medium apple
Activity	Stressful day at work	30 minute walk

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Patient Health Questionnaire

This questionnaire is about stress and how it may be affecting your health. Stress can increase blood pressure, blood sugar, cholesterol levels and the risk for heart disease and stroke. Stress can also affect quality of life and how well individuals are able to care for themselves and their family.

Some of the questions asked may seem sensitive. You don't have to answer these questions. However, if you decide not to answer some or all of the questions, it may affect the quality of care we can offer. The only people who will see this information are the health care providers directly involved in your care.

Counselling services are available within the Diabetes Centre Calgary and in the community to help address any concerns you have. Ask your nurse or dietitian for more information.

If you're feeling very stressed, please contact the Distress Centre at (403) 266-4357.

Name: ______________________________ **Date:** ____________________

1. Over the last 2 weeks how often have you been bothered by any of the following problems.	**Not at all**	**Several Days**	**More than half the days**	**Nearly everyday**
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed or hopeless.	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, that you're a failure or have let yourself or your family down?	☐	☐	☐	☐
g. Trouble concentrating on things such as reading the newspaper or watching television?	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around more than usual?	☐	☐	☐	☐
i. Had thoughts that you would be better off dead or of hurting yourself in some way?	☐	☐	☐	☐

2. Questions about anxiety.	**No**	**Yes**
a. In the **last 4 weeks**, have you had an anxiety attack or had a sudden feeling of fear or panic?	☐	☐
b. Has this ever happened before?	☐	☐

3. Over the last 4 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**
a. Feeling nervous, anxious, on edge or worrying a lot about different things.	☐	☐	☐
b. Becoming easily annoyed or irritable.	☐	☐	☐
c. Feeling restless so it's hard to sit still.	☐	☐	☐
d. Muscle tension, aches or soreness.	☐	☐	☐

Alberta Health Services

4. Questions about eating.	No	Yes
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat within a two hour time period what most people would regard as an unusually large amount of food?	☐	☐

5. Questions about your drinking habits. Answer them as they apply over that past 12 months.
a. How often do you have a drink containing alcohol? ☐ Never ☐ Monthly or less ☐ Two to four times per month ☐ Two to three times per week ☐ Four or more times per week **If you checked "never" go to question 6.**
b. How many drinks containing alcohol do you have on a typical day when you're drinking? ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-9 ☐ 10 or more
c. How often do you have 6 or more drinks on one occasion? ☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily
d. Has a relative, friend or other health care worker been concerned about your drinking or suggested that you cut down? ☐ No ☐ Yes, but not in the last year ☐ Yes, during the last year

6. In the last 12 months, how often have you used tobacco products?
☐ Never ☐ Once or twice ☐ Monthly ☐ Weekly ☐ Daily or almost daily

7. Over the last 4 weeks, how often have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health?	☐	☐	☐
b. Worrying about the health of friends or loved ones?	☐	☐	☐
c. Your weight or how you look?	☐	☐	☐
d. Little or no sexual desire or pleasure during sex?	☐	☐	☐
e. Difficulties with husband/wife, partner/lover or boyfriend/girlfriend?	☐	☐	☐
f. The stress of taking care of children, parents or other family members?	☐	☐	☐
g. Stress at work, outside of the home or school?	☐	☐	☐
h. Financial problems or worries?	☐	☐	☐
i. Having no one to turn to for emotional help?	☐	☐	☐
j. Having no one to turn to for practical help, e.g. transportation, household chores.	☐	☐	☐
k. Something bad that happened recently?	☐	☐	☐

8. What's the most stressful thing in your life right now?

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9. If you checked off any problems on this questionnaire, how difficult have these problems made it for you to take care of your health? Ex. Being physically active or eating healthy meals.

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

10. Are you taking any medications for anxiety, depression, sleep or stress? ☐ Yes ☐ No

11. Has a friend, relative or anyone else ever expressed concern about your use of prescription or non-prescription drugs? Ex. Sleeping pills, pain killers, diet pills, marijuana, etc. ☐ Yes ☐ No

12. Are you seeing a physician or therapist for any concerns you identified in this questionnaire ☐ Yes ☐ No