The Valley Metabolic Program Health Questionnaire

NAME: _____ DATE: _____

DATE of BIRTH: _____ EMAIL: _____

Introduction

Thank you in advance for taking the time to fill out this questionnaire in preparation for your consultation with Dr. Mindrum at the Port Williams Internal Medicine office. Please allow yourself 30 to 45 minutes to fill out this questionnaire, ideally at a quiet time of day, and with adequate privacy. Later in the survey you will be asked about your interest in engaging in a dietary intervention to improve your diabetes or other metabolic condition. Please consider having your medication list and glucose log (if you have one) in preparation for filling out this questionnaire. If you have any questions you may call the office during business hours at (902) 542-0990.

Reason for Referral

1. Why were you referred to Dr. Mindrum? (If you have Type 2 Diabetes, please choose this answer even if you have other conditions).

- ☐ Pre DM (go to question 2)
- ☐ Fatty Liver (go to question 3)
- ☐ PCOS (go to question 4)
- ☐ Obesity (go to question 5)
- ☐ Type 2 DM (go to question 6)

Duration

2. How many years have you had pre-Diabetes? _____ yrs (go to question 52)
3. How many years have you had fatty liver disease? _____ yrs (go to question 52)
4. How many years have you had PCOS? _____ yrs (go to question 52)
5. How many years have you had obesity? _____ yrs (go to question 52)
6. How many years have you had type 2 diabetes? _____ yrs (proceed to question 7).

Diabetes Complications

7. Have you ever been diagnosed with

- ☐ angina, heart attack, stent or open heart surgery
- ☐ stroke or mini-stroke (TIA)
- ☐ claudication, decreased blood flow to the legs, or surgery of an artery due to lack of blood flow
- ☐ none of the above

8. Have you ever been diagnosed with

- ☐ decreased or abnormal sensation in the feet
- ☐ decreased kidney function
- ☐ retinopathy or required laser treatment for your eye
- ☐ none of the above

Insulin

9. Are you on insulin?

☐ Yes ☐ No (skip to question21)

10. Around how many years have you been on insulin? _____

11. From the time of diagnosis, were you put on insulin in less than 6 months?

☐ Yes ☐ No

12. How many total units of long acting insulin do you take in a day? Examples of long acting insulin include basaglar, lantus, NPH, Humulin-N, and Toujeo. If you take these twice a day please add up the two doses to calculate the total. For instance if you take Basaglar 10 units in the morning and 12 at night, the answer for total units would be 10 + 12 = 22

☐ _____ units

13. How often do you take the long acting (also called basal) insulin?

☐ Once a day ☐ Twice a day

14. Do you take rapid (also considered meal time or short acting) insulin? (if no, go to question 21)

☐ Yes ☐ No

15. Do you take meal time insulin with breakfast?

☐ Yes ☐ No

16. How many units of meal time insulin do you take with breakfast typically? _____ units

17. Do you take meal time insulin with lunch?

☐ Yes ☐ No

18. How many units of insulin do you typically take at lunch? _____ units

19. Do you take meal time insulin at supper (evening meal)?

☐ Yes ☐ No

20. How many units of meal time insulin do you typically take with your evening meal? _____ units

Carbohydrate Counting and Glucose Readings

21. Do you know how to count carbohydrates?

☐ Yes ☐ No

22. How skilled are you at counting carbohydrates? basic skills, moderate skills, advanced skills

☐ basic skills ☐ moderate skills ☐ advanced skills

23. Do you know about how many grams of carbohydrates you eat in a typical day? (if no, go to question 25)

☐ Yes ☐ No

24. On average, how many grams of carbohydrates are you eating in a typical day? _____ grams

25. Have you ever used a book or program (such as chronometer or fitness pal) to track calories, carbohydrates, or fats?

☐ Yes ☐ No

26. Do you have a scale at home to weigh food?

☐ Yes ☐ No

27. Do you test your blood glucose at home? (if no, skip questions 29 to 32)

☐ Yes ☐ No

28. Do you have a glucose meter and supplies necessary to check your blood glucose if needed?

☐ Yes ☐ No

29. In an average day how often do you check your blood sugars? _____ times a day

30. In the last three days what was your highest blood sugar reading? _____

31. In the last three days, what was your lowest blood sugar reading? _____

32. How satisfied are you with your current glucose control?

☐ very satisfied ☐ somewhat satisfied ☐ unsatisfied, ☐ very unsatisfied

33. Have you ever had a seizure or loss of consciousness from a low blood sugar? (if no, go to question 35)

☐ Yes ☐ No

34. How long ago did this occur? _____

35. Do you have a glucagon pen?

☐ Yes ☐ No

36. Do you get symptoms when you blood sugar is less than 4?

☐ Yes ☐ No

Diabetes Targeted Therapies

37. Are you taking metformin?

☐ Yes ☐ No

38. Did you have an intolerance to metformin in the past?

☐ Yes ☐ No

39. Do you have a functioning home blood pressure monitor ?

☐ Yes ☐ No

40. Do you check your home blood pressures?

☐ Yes ☐ No

41. Is your blood pressure typically less than 130/80 at home or in your doctor's office?

☐ Yes ☐ No

42. Do you take a statin (cholesterol medication)?

☐ Yes ☐ No

43. Have you had a foot exam in the past year?

☐ Yes ☐ No

44. Have you ever had a foot infection, ulcer, or amputation?

☐ Yes ☐ No

45. Please check any of the following complications that you have experienced (if any)?

☐ foot infection, ☐ foot ulcer, ☐ amputation

46. Have you had an eye exam in the past year?

☐ Yes ☐ No

47. Did you get your annual influenza vaccine in the past year?

☐ Yes ☐ No

Diabetes Centre Questionnaire

48. Have you ever been to a diabetes centre? (if no, go to question 52)

☐ Yes ☐ No

49. Are you a client of any of the following diabetes centres?

☐ VRH ☐ Digby

☐ SMH ☐ Windsor

☐ Annapolis ☐ Dietitian outside of a Diabetes Centre

50. How many years have you been a client of the diabetes centre? _____

51. How long ago was your last visit to a diabetes centre? _____

Weight History

52. Do you have a home scale to measure your weight?

☐ Yes ☐ No

53. What is your current (known or estimated) weight in pounds? _____

54. What is your height in inches? (Example: A person that is 5 feet tall is 60 inches, so if you were 5 feet 7 inches, your height would be 60 + 7 = 67). _____

55. What was your weight around the age of 21? _____

56. In your adult life, what was your lightest weight? _____

57. In your adult life, what was your heaviest weight? _____

58. During the past 6 months my weight?

☐ decreased by more than 10 lbs ☐ increased by 5 to 10 lb

☐ decreased by 5 to 10 lbs ☐ increased by more than 10 lbs

☐ has been relatively stable

59. In your adult life how many times have you lost and regained more than 10 lbs from attempts at dieting? _____

60. Have you ever lost more than 20 lbs and kept if off for more than a year?

☐ Yes ☐ No

61. Describe the type of diet you used during this time to lose and maintain weight:

_____

62. Have you experience any significant physical or emotional symptoms while attempting to lose weight or after losing weight?

☐ Yes ☐ No

63. We do not have any particular goal weight for you in mind but your goals may be different. Please also note that a "clinical success" is a 10% weight loss over the course of a year (for example, 10 pounds of weight loss for every 100 pounds of body weight). If you are desiring to lose weight, how much weight in pounds would you like to lose in the upcoming year? _____

64. How old were you when you last weighed this amount? _____

65. How long were you able to maintain that weight? _____

Medical History

66. Have you had any of the following health issues?

- ☐ Diabetes Mellitus Type 2
- ☐ Heart attack
- ☐ myocardial infarction, bypass surgery, or stent placed in a heart artery (coronary artery disease)
- ☐ Angina
- ☐ Atrial Fibrillation
- ☐ Stroke
- ☐ Mini-stroke or TIA
- ☐ Heart rhythm problem
- ☐ Kidney disease
- ☐ Protein in the urine
- ☐ Kidney stones
- ☐ Retinopathy or need for laser treatment in the back of t eye
- ☐ Decreased sensation in the feet or pain in the feet
- ☐ Arterial disease of the legs
- ☐ Amputations
- ☐ Emphysema or COPD
- ☐ Asthma
- ☐ Sleep Apnea
- ☐ Fatty Liver
- ☐ Irritable Bowel Syndrome
- ☐ Heart burn or reflux
- ☐ Barrett's esophagitis
- ☐ Ulcerative colitis
- ☐ Crohn's disease
- ☐ Gallstones
- ☐ Gallbladder surgery
- ☐ Bariatric surgery
- ☐ Bowel resection
- ☐ B12 deficiency
- ☐ Anemia or low iron
- ☐ Low thyroid function
- ☐ Osteoarthritis
- ☐ Gout
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Diabetic ketoacidosis
- ☐ Diabetes Mellitus Type 1
- ☐ Pancreatitis
- ☐ Migraine Headache
- ☐ Other diagnosis or surgeries:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

67. Medication List (please give Amanda your medication, medication list or number at the pharmacy).

68. Do you have any drug allergies

- ☐ Yes (please list): _____
- ☐ No

Social History

69. Please describe your relationship status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ In a relationship
- ☐ Common law
- ☐ Separated

70. What is your employment status?

- ☐ Full time
- ☐ Unemployed
- ☐ On disability
- ☐ Part time
- ☐ Retired
- ☐ Work inside the home

71. What type of work do you do or did you do? _____

72. What is the highest year of school you completed?

- ☐ Did not complete high school
- ☐ High school diplomats
- ☐ Community college diploma
- ☐ Bachelor's
- ☐ Masters
- ☐ doctorate

72. Have you every smoked? (if no, skip to question 78)

- ☐ Yes
- ☐ No

73. How many years have you smoked? _____

74. Are you still a smoker? (if no, skip to question 78)

- ☐ Yes
- ☐ No

75. How many yrs ago did you quit smoking? _____

76. How many packs of cigarettes do you smoke a day?

- ☐ - 1/4 or less
- ☐ 1/2
- ☐ 3/4
- ☐ 1
- ☐ -1.5

77. Are you interested in quitting smoking?

- ☐ Yes
- ☐ No

78. Do you drink alcohol?

- ☐ Yes
- ☐ No

79. If yes, how many drinks per week? A drink is 1.5 ounces of liquor, 1 normal size beer or 5 ounces of wine _____

80. Tell us about your physical activity level

- ☐ minimal physical activity
- ☐ mild activity such as daily chores, garden work, casual walks but no routine exercise
- ☐ moderately active: walk, run or other activity for 30 min a day at least 5 days a week
- ☐ very active, exercises regularly

81. What is the name of your pharmacy? _____

82. Where is your pharmacy located? _____

83. Do you have a private drug plan?

☐ Yes ☐ No

84. What is the name of the private drug plan? _____

85. Please estimate the monthly out of pocket cost for your prescription medications:
$_____ / month

86. Do you have access to the internet?

☐ Yes ☐ No

87. Would it be okay to communicate with you through email?

☐ Yes ☐ No

Family History

88. Does your mother, father, brother, or sister have type 2 diabetes?:

☐ Yes ☐ No

89. Was your mother, father, brother or sister diagnosed with heart disease before the age of 65?

☐ Yes ☐ No

Functional History

90. Please Rate your symptoms for Fatigue

☐ None ☐ Mild ☐ Moderate ☐ Severe

91. Mental fogginess or difficulty concentrating

☐ None ☐ Mild ☐ Moderate ☐ Severe

92. Shortness of breath

☐ None ☐ Mild ☐ Moderate ☐ Severe

93. Abdominal Bloating

☐ None ☐ Mild ☐ Moderate ☐ Severe

94. Constipation

☐ None ☐ Mild ☐ Moderate ☐ Severe

95. Loose stool

☐ None ☐ Mild ☐ Moderate ☐ Severe

96. Heart burn

☐ None ☐ Mild ☐ Moderate ☐ Severe

97. Migraine headache

☐ None ☐ Mild ☐ Moderate ☐ Severe

98. Joint or muscle pain

☐ None ☐ Mild ☐ Moderate ☐ Severe

99. Quality of sleep

☐ None ☐ Mild ☐ Moderate ☐ Severe

100. How health is impacting your overall quality of life:

☐ None ☐ Mild ☐ Moderate ☐ Severe

Dietary History

101. Please describe any financial hardship in affording healthy food:

☐ no hardship ☐ mild hardship ☐ moderate hardship ☐ severe hardship

102. Who does most of the grocery shopping ?

☐ self ☐ partner ☐ both

103. Who prepares most of the meals?

☐ self ☐ partner ☐ both

104. How often do you eat out at restaurants?

☐ more than twice a week ☐ once a week

☐ twice a week ☐ once a month or less

105. How confident are you at preparing meals and working in the kitchen?

☐ not confident ☐ somewhat confident ☐ pretty confident ☐ very confident

106. Does anyone else in your immediate household take diabetes medications or blood pressure lowering medications?

☐ yes ☐ no

107. Do you eat salad greens on most days?

☐ yes ☐ no

108. How would you characterize your current way of eating?

☐ vegetarian ☐ carnivore (eats only animals) ☐ standard Canadian diet

☐ vegan ☐ follow a low fat diet

☐ omnimove (eats plants and animals) ☐ follow a low carbohydrate diet

109. How many sugary drinks have you had in the past week (juice, pop, flavored or specialty coffees/ cappuccinos)? _____

110. How many times have you snacked after dinner this past week? _____

111. How many meals a day do you typically eat? _____

112. During the past 6 months did you often eat an usually large amount of food within a two hour window? (if no, skip to question 117)

☐ yes ☐ no

Impulsive Eating

113. When you ate an unusually large amount of food did you often feel out of control or that you could not stop eating?

☐ yes ☐ no

114. During the last 6 months how often did you have times where you felt out of control while eating a large amount of food?

☐ less than one day a week
☐ two or three days a week
☐ nearly every day
☐ one day a week
☐ four or five days a week

115. Did you have any of the following experiences during these episodes? Choose all that apply:

☐ eating more rapidly than usual
☐ eating large amounts of food without feeling physically hungry
☐ feeling disgusted, depressed or guilty after overeating eating large amounts of food throughout the day with no planned meal times.
☐ eating until feeling uncomfortably full
☐ eat alone because of feeling embarrassed by how much food is being consumed

Self Reflection

117. In general during the past 6 months how does your weight or shape affected your feelings about yourself as a person compared to other aspects of her life such as how to work, being a parent, or getting along with others?

☐ Not very important
☐ how I feel by myself
☐ Among the main things that affect how I feel by myself
☐ The most important things that affected how I feel by myself

118. In the past 6 months if he ever make herself vomit to avoid gaining weight?

☐ yes ☐ no

119. Would you be interested in meeting with a private psychologist for guidance? To meet with the psychologist, we recommend checking with her insurance plan to make sure he have coverage for this service. Alternatively you may opt to pay out of pocket for the support.

☐ yes ☐ no

120. How satisfied are you with your current weight?

☐ very satisfied
☐ moderately satisfied
☐ slightly satisfied
☐ neutral
☐ slightly dissatisfied
☐ moderately
☐ very dissatisfied

121. How satisfied are you with your shape?

- ☐ very satisfied
- ☐ moderately satisfied
- ☐ slightly satisfied
- ☐ neutral
- ☐ slightly dissatisfied
- ☐ moderately dissatisfied
- ☐ very dissatisfied

122. In general I am

- ☐ Very happy with who I am
- ☐ happy with who I am
- ☐ okay with who I am but have some mixed feelings
- ☐ unhappy with who I am, very un happy with who I am

123. As compared to most people I think I have

- ☐ very good self-esteem
- ☐ good self-esteem
- ☐ average self-esteem
- ☐ poor self-esteem
- ☐ very poor self-esteem

Readiness for Change

124. Life is fairly calm right now and I feel I'm ready to make a change about diet and lifestyle. My stress basket is not to full:

☐ yes ☐ no

125. I believe I can change my eating, physical activity, and behaviour habits

☐ yes ☐ no

126. Family, friends, or both we will support my lifestyle change efforts

☐ yes ☐ no

127. I'm going to look at past successes and failures and weight loss and diabetes management to see what motivates me and also to see what our mite barriers to success

☐ yes ☐ no

128. I can review transitioning to a new pattern of eating as a possible episode of experience

☐ yes ☐ no

129. I'm willing to share and are listed to others experiencing a group session

☐ yes ☐ no

130. How confident do you feel that you can make a healthy lifestyle change?

☐ Highly confident ☐ Moderately confident ☐ Slightly confident ☐ Not confident at all

131. How motivated do you feel to make a healthy change in lifestyle?

☐ Highly motivated ☐ Moderately motivated ☐ Slightly motivated ☐ Not motivated at all

Review of Information

132. Please take a moment to read the information material provided. Once completed please indicate that you have read the information packet by checking yes.

☐ yes ☐ no

Confidence in Enrolment

133. At this time how confident do you feel you will enrol in the VMP:

- ☐ Very confident I will enrol.
- ☐ I don't want to enrol at this time.
- ☐ I would like to enrol but the timing is wrong.
- ☐ I would like to enrol but the cost is too much at this time.
- ☐ I am interested but still undecided at this time.

Consent

134. "I have reviewed all of the offered material and understand the risks and benefits of engaging in a low carbohydrate diet for the management of my metabolic disease as outlined. I understand the importance of close medical monitoring when engaged in a low carbohydrate or ketogenic diet. I understand there are other healthy dietary options that I could pursue as well as other resources available in the community. I understand that there is no out of pocket expense for seeing Dr. Mindrum in consultation or for follow up visits. I understand that I have no obligation to join the Valley Metabolic Program and that my consultation with Dr. Mindrum is not dependent on whether or not I will join the VMP. I understand that if I enrol in the VMP, I can leave the program at any time without need to give an explanation. If I enrol in the Valley Metabolic Program, I agree to pay the fee associated with the program which is used to support the services of a professional dietitian, supplies, and for work provided by the physician that is not reimbursed by MSI toward times spent in administration, program development and oversight. I agree to having my medical information collected in an anonymous fashion for quality improvement or for publication purposes. If I engage in group visits I acknowledge that it is up to me about what personal information to share. I commit to not sharing personal information of others and was given explicit permission by that individual to do so."

- ☐ I consented to the above
  - ☐ Signature: _____
  - ☐ DATE: _____
- ☐ I am not ready to consent to the above

Thank you so much for taking the time to fill out this questionnaire. Please give this to Amanda at the front desk.