DiabetesCare Guelph

Before Your First Appointment…

Please complete these questions before your appointment at Diabetes Care Guelph

How long have you had diabetes?	
Do you check your blood sugars? O Yes O No	If yes, how often:
Do you have any allergies to medications or food? O Yes O No	If yes, please list:
Do you smoke? O Yes O No O I quit ___ months/years ago	If yes, how many cigarettes per day?
On average, how many alcoholic beverages do you drink per week?	
Date of last flu shot: **Date of last eye exam**: **Date of last dentist appointment**: **Date of pneumonia vaccine**: **Name of pharmacy you go to** (and street name): **How do you pay for your medication**? [ex. Self, OHIP, Insurance company (please name)]	**What does your daily routine look like?** (Ex. 8:30 am – get up eat breakfast, go to work (desk job), 12:00 – have lunch, go for walk around the block, home by 5:30pm - make dinner, tennis Tuesday and Thursday evenings)

In addition to this form, please also bring with you:

- Current medications and/or supplements in their original bottles
- Record of blood sugar values and meter
- Completed 3 day food record
- Completed Health and Well Being Survey
- The Sexual Health Inventory for Men form (provided) if you are male

Have you had a weight gain or loss in the past 6 months? O Yes O No	How much? Please specify
Have you seen a dietitian in the past? O Yes O No	Do you have problems swallowing or chewing your food? O Yes O No
How often do you eat out in restaurants? O never O once a month O once a week O 1-2 times a week	
How many times a day do you eat?	
Who prepares most of the food at home?	Who does the grocery shopping?

Do you add salt to your food when you are cooking? O Yes O No	Do you add salt to your food or drinks? O Yes O No	Do you add sugar to your food or drinks? O Yes O No	Do you use a sweetener? O Yes O No

Are there any foods that you avoid?

Please mark the beverages you drink more than twice a week:
O Coffee O Tea O Water O Juice

O Regular Pop O Diet Pop

O Whole Milk O 2% Milk O 1% Milk O Skim Milk

Is there anything you would like to do differently that would help you manage your diabetes?

How important are the following aspects of your health?

	Least important				Most important
Blood Pressure Control	1	2	3	4	5
Blood Sugar Control	1	2	3	4	5
Cholesterol Control	1	2	3	4	5
Healthy Eating	1	2	3	4	5
Physical Activity	1	2	3	4	5

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