# BETTER Prevention Practitioner™
# Practice Case Study – Instructions
# ♠ Patient Z ♠

**Instructions:**

You are a PP who is getting ready for an appointment with a patient. The patient has filled out a BETTER Health Survey™ and you have a summary of their medical chart.

1. Go through the survey and the medical chart, and highlight/write down anything that seems important (i.e. any "yes" answers, any past screening the patient completed etc.)
2. Go through the BETTER Care Map™ and determine:
    a. any eligible screening actions for your patient
    b. if your patient is at higher risk for cancer, diabetes and/or heart disease
3. Fill out a Bubble Diagram
4. Fill out a Prevention Prescription
5. Upload your completed patient case to your sync account: https://www.sync.com/

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**TRAINEE VERSION**

Date completed:

JAN / 1 / 2000
(month) (day) (year)

# BETTER
## Health Survey™
## Comprehensive

Name: **Patient Z ♠**

Thank you for completing the BETTER Health Survey™!

Your answers will help us provide better care for you.

During the visit, you and your healthcare provider will talk about how you can improve your health and the screening tests recommended for you. You will be able to set your own health goals and create a plan to help you achieve them.

Later, your healthcare provider will check with you to review your progress, help you change your plan, if needed, and set new goals.

**INSTRUCTIONS: Please answer all questions as best you can.**

**For each question, please circle the number that matches your answer or fill in the blank as needed.**

**Your answers will help your healthcare provider get ready for your Prevention visit.**

**You are free to refuse to answer any question you wish.**

**If you wish to make a comment on any of the questions, please use the space at the end of the survey.**

***Please complete your survey and return it to your healthcare provider.***

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## SECTION A: GENERAL INFORMATION

***Instructions: These questions are for both men and women.***

***For each of the following questions, please circle the number that matches your response or fill in the blank.***

QRISK2 & Screening

**1. What sex were you assigned at birth?** *Your sex at birth helps us to know what kinds of screening tests you may need.* (Circle one number)

1. Male
2. Female
3. Decline to answer

**2. What is your current gender identity?** (Circle all that apply)

1. Male → ***go to question 4***
2. Female → ***go to question 4***
3. Transgender Male/Transman/FTM
4. Transgender Female/Transwoman/MTF
5. Genderqueer
6. Additional category (Please specify): _____
7. Decline to answer

**3. What pronouns do you prefer?** *For example he, she, they, etc.* (Write your preferred pronouns in the space below)

_____

QRISK2 & Screening

**4. What is your date of birth?** (Write your month and year of birth in the space below)

_____ (month) _____ (year)

e.g. Feb 1959

**Age: 49**

QRISK2/BMI

**5. How tall are you without shoes on?** (Write your height in feet and inches or centimetres in the space below)

____ (feet) ____(inches) **OR** **158** (cm)



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QRISK2/BMI

**6. How much do you weigh?** (Write your weight in pounds or kilograms in the space below)

_____ (pounds) **OR** **73** (kg)

**BMI:** 29.2

## SECTION B: CHRONIC HEALTH CONDITIONS

***Instructions: These questions are for both men and women.***

***The next questions ask about some health conditions that you may have that were diagnosed by a healthcare professional.***

**7. Have you ever been told by a healthcare professional that you had any of the following health conditions?**

Diabetes Risk/ ACE & ARB

**7a. Diabetes?** *Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood.* (Circle one number)

1. Yes
2. No → ***go to question 7c***
3. Don't know → ***go to question 7c***

**7b. What type of diabetes were you diagnosed with?** (Circle one number)

1. Type 1 (formerly juvenile diabetes, usually diagnosed at a young age and is only treated with insulin)
2. Type 2 (formerly non-insulin dependent diabetes, can be treated with pills or insulin)
3. Don't know

CVD

**7c. A stroke?** *A stroke occurs when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.* (Circle one number)

1. Yes
2. No
3. Don't know



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CVD/Diabetes/ACE & ARB

**7d.** **Angina, a heart attack, congestive heart failure (CHF), coronary artery disease (CAD), or peripheral vascular disease (PVD)?** *Angina refers to chest pain, including a squeezing, suffocating, or burning feeling. A heart attack is when blood flow is blocked from a section of the heart, not allowing oxygen to get in. Congestive heart failure is a condition that develops after the heart becomes damaged or weakened, limiting the movement of blood. Coronary artery disease is a type of heart disease that happens when arteries in the heart are blocked. Peripheral vascular disease is a narrowing of the peripheral arteries serving the legs, stomach, arms and head.* (Circle one number)

1. Yes
2. No
3. Don't know

Diabetes Risk/ BP/ACE & ARB

**7e.** **Hypertension or high blood pressure?** *High blood pressure, also called hypertension, means there is too much pressure in your blood vessels.* (Circle one number)

1. Yes
2. No
3. Don't know

QRISK2

**7f.** **Atrial fibrillation (Afib or AF)?** *Atrial fibrillation is a condition involving an irregular heart rhythm, known as an arrhythmia, which is an electrical disturbance of the heart. Afib can cause the heart to beat very fast, sometimes more than 150 beats per minute.* (Circle one number)

1. Yes
2. No
3. Don't know

QRISK2/Diabetes

**7g.** **Chronic kidney disease or chronic renal failure?** *Chronic kidney disease or chronic renal failure describes a gradual loss of kidney function over time.* (Circle one number)

1. Yes
2. No
3. Don't know



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QRISK2

**7h. Rheumatoid arthritis?** *Rheumatoid arthritis happens when the immune system is not working properly, causing pain and swelling in the wrist and small joints of the hand and feet.* (Circle one number)

1. Yes
2. No
3. Don't know

Diabetes Risk

**7i. Hyperlipidemia or high cholesterol, or high lipid (fat) levels, such as cholesterol, in the blood?** (Circle one number)

1. Yes
2. No
3. Don't know

CVD

**7j. A genetic condition for cholesterol or familial hypercholesterolemia?** (Circle one number)

1. Yes
2. No
3. Don't know

## SECTION C: COLORECTAL (BOWEL) SCREENING

***Instructions: These questions are for both men and women.***

***For each of the following questions, please circle the number that matches your response or fill in the blank.***

Colorectal Cancer Screening

**8. Have you ever been told by a healthcare professional that you had any of the following health conditions?**

**8a. Colorectal (bowel) cancer?** *Colorectal cancer is a type of cancer that develops in the colon and/or the rectum.* (Circle one number)

1. Yes → ***go to Section D (page 9)***
2. No
3. Don't know



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**8b. Crohn's disease?** *Crohn's disease is a condition in which the gastrointestinal tract is inflamed over a long period of time.* (Circle one number)

1. Yes
2. No
3. Don't know

**8c. Ulcerative Colitis?** *Ulcerative colitis is a chronic inflammation of the colon that produces ulcers in its lining*. (Circle one number)

1. Yes
2. No
3. Don't know

**8d. Familial Adenomatous Polyposis (FAP)?** *FAP is an inherited condition in which many polyps form on the inside walls of the colon and rectum.* (Circle one number)

1. Yes
2. No
3. Don't know

**8e. Hereditary Nonpolyposis Colon Cancer (HNPCC) or Lynch syndrome?** *HNPCC or Lynch Syndrome is an inherited disorder.* (Circle one number)

1. Yes
2. No
3. Don't know

**9. Have any of your close relatives (parents, siblings, children) tested positive for a genetic mutation related to Lynch syndrome?** *Lynch Syndrome is an inherited disorder.* (Circle one number)

1. Yes
2. No
3. Don't know



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**10. Have you had genetic testing for a mutation related to Lynch syndrome?** (Circle one number)

1. Yes
2. No → ***go to question 12***
3. Don't know → ***go to question 12***

**11. Did you test positive for a genetic mutation related to Lynch syndrome?** (Circle one number)

1. Yes
2. No
3. Don't know

**12. Have you ever had a fecal occult blood test (or FOBT) or fecal immunochemical test (or FIT)?** *A FOBT is a test to check for blood in your stool, where you have a bowel movement and use a stick to smear a small sample on a special card. A FIT is a test to check for blood in your stool, where you have a bowel movement and use a swab to collect a sample.* (Circle one number)

1. Yes
2. No → ***go to question 14***
3. Don't know → ***go to question 14***

**13. When was the last time you had a FOBT or FIT?** (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never

**14. Have you ever had a colonoscopy?** *A colonoscopy is a test where a long tube is inserted into the rectum to view the bowel for early signs of cancer and other health problems.* (Circle one number)

1. Yes
2. No → ***go to question 16***
3. Don't know → ***go to question 16***



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Colorectal Cancer Screening

**15. When was the last time you had a colonoscopy?** (Circle one number)

1. Less than 2 years ago
2. 2 years to less than 5 years ago
3. 5 years to less than 8 years ago
4. 8 years to less than 10 years ago
5. 10 or more years ago
6. Don't know
7. Never

**16. Have you ever had a sigmoidoscopy or other test for colorectal cancer?** *A sigmoidoscopy is a test where a long tube is inserted into the rectum to view the bowel for early signs of cancer and other health problems.* (Circle one number)

1. Yes
2. No → ***go to Section D***
3. Don't know → ***go to Section D***

**17. When was the last time you had a sigmoidoscopy or other test for colorectal cancer?** (Circle one number)

1. Less than 2 years ago
2. 2 years to less than 5 years ago
3. 5 years to less than 8 years ago
4. 8 years to less than 10 years ago
5. 10 or more years ago
6. Don't know
7. Never



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## SECTION D: SCREENING TESTS AND CHRONIC HEALTH CONDITIONS FOR WOMEN

***Instructions: These questions are for women. If you are male, please go to Section E (page 14).***

***For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.***

QRISK2 Eligibility

**18. Are you post-menopausal? That is, have you not had your period for at least 1 year?** (Circle one number)

(1.) Yes
2. No
3. Don't know

**19. Have you ever been told by a healthcare professional that you had any of the following health conditions?**

Diabetes Risk

**19a. Gestational diabetes. That is, diabetes during pregnancy?** (Circle one number)

1. Yes
(2.) No
3. Don't know

Cervical Cancer Screening

**19b. Immunocompromised?** *Being immunocompromised means having a weakened immune system* (Circle one number)

1. Yes
(2.) No → ***go to question 19d***
***3.*** Don't know → ***go to question 19d***



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**19c. Please tell us the reason(s) that you have been told you are immunocompromised from the list below.** (Circle all that apply)

1. You are an organ transplant recipient.
2. You have chronic use of corticosteroids. *Corticosteroids are used to provide relief for inflamed areas of the body. Chronic use means that you have used the medication for at least a month.*
3. You have been prescribed an alkylating agent, antimetabolite, and/or tumor necrosis factor (TNF) blocker. *An alkylating agent is a type of medication that is used in the treatment of cancer. Antimetabolites are medications used to treat certain diseases associated with abnormally rapid cell growth. A TNF blocker is a medication that helps stop inflammation from conditions such as arthritis.*
4. Other (Please specify):_____
5. Don't know

**19d. Cervical cancer?** *Cervical cancer is a type of cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina).* (Circle one number)

***1.*** Yes → ***go to question 24***
(2.) No
3. Don't know

**20. Have you ever had:**

**20a. A hysterectomy. That is, your womb/uterus removed?** (Circle one number)

1. Yes
(2.) No → ***go to question 21***
3. Don't know → ***go to question 21***

**20b. Did they remove your cervix ("total hysterectomy") at the time of the hysterectomy?** (Circle one number)

1. Yes → ***go to question 24***
2. No
3. Don't know



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Cervical Cancer Screening

**21. Have you had a Pap test in the past 3 years?** *A Pap test is done to test for cervical cancer or other conditions, like infections of inflammation. It involves putting a speculum into the vagina and using a small brush or spatula to gently remove cells from the cervix to be checked under a microscope.* (Circle one number)

1. Yes
2. No → ***go to question 24***
3. Don't know → ***go to question 24***

**22. When was the last time you had a Pap test?** (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know

**23. Were any of the Pap tests abnormal?** (Circle one number)

1. Yes
2. No
3. Don't know

**24. Have you ever been told by a healthcare professional that you had any of the following health conditions?**

Breast Cancer Screening

**24a. Ovarian cancer?** *Ovarian cancer is a type of cancer that forms in tissues of the ovary.* (Circle one number)

1. Yes
2. No
3. Don't know

Diabetes

**24b. Polycystic ovarian disease or polycystic ovary syndrome?** *Polycystic ovarian disease is a hormonal disorder in which a woman's hormones are out of balance*. (Circle one number)

1. Yes
2. No
3. Don't know



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**24c. Breast cancer?** *Breast cancer is a type of cancer that forms in tissues of the breast.* (Circle one number)

1. Yes
2. No
3. Don't know

**25. Have you ever had a bilateral mastectomy? That is, have you had both of your breasts surgically removed?** (Circle one number)

1. Yes → ***go to Section E (page 13)***
2. No
3. Don't know

**26. Have any of your close relatives (parents, siblings, children) tested positive for a mutation in the BRCA1 or BRCA2 genes?** *BRCA1 and BRCA2 are genes that normally help to stop cell growth.* (Circle one number)

1. Yes
2. No
3. Don't know

**27. Have any of your other relatives (aunts, uncles, cousins, grandparents) tested positive for a mutation in the BRCA1 or BRCA2 genes?** (Circle one number)

1. Yes
2. No
3. Don't know

**28. Have you had genetic testing for a mutation in the BRCA1 or BRCA2 genes?** (Circle one number)

1. Yes
2. No → ***go to question 30***
3. Don't know → ***go to question 30***

**29. Did you test positive for a BRCA1 or BRCA2 gene mutation?** (Circle one number)

1. Yes
2. No
3. Don't know



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**30. When was the last time you had a mammogram?** *A mammogram is a low-dose x-ray of the breast.* (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never



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## SECTION E: MEDICATIONS

***Instructions: These questions are for both men and women.***

***For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.***

Diabetes Risk

**31. The table below provides a list of medications or therapies that people may be prescribed.**

**For each medication or therapy in the table below, please circle the number that best indicates if you have ongoing use of the medication or therapy in an oral form (for example, pills, capsules or tablets).**

- For "Yes", circle the number 1;
- For "No", circle the number 2; and
- For "Don't know", circle the number 3.

| | **Are you currently using the following medication or therapy?** | | |
|---|---|---|---|
| **Medication or therapy** | **Yes** | **No** | **Don't know** |
| Aripiprazole (Abilify) | 1 | (2) | 3 |
| Clozapine (Clozaril) | 1 | (2) | 3 |
| Dexamethasone | 1 | (2) | 3 |
| Highly active antiretroviral therapy (HAART) | 1 | (2) | 3 |
| Hydrocortisone | 1 | (2) | 3 |
| Olanzapine (Zyprexa) | 1 | (2) | 3 |
| Paliperidone (Invega) | 1 | (2) | 3 |
| Prednisone | 1 | (2) | 3 |
| Quetiapine (Seroquel) | 1 | (2) | 3 |
| Risperidone (Risperdal) | 1 | (2) | 3 |
| Ziprasidone (Zeldox) | 1 | (2) | 3 |



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## SECTION F: LIFESTYLE AND NUTRITION

***Instructions: These questions are for both men and women.***

***The next group of questions ask about some of your lifestyle behaviours such as smoking, physical activity, eating habits and alcohol intake.***

***For each question, please circle the number that matches your response or fill in the blank as appropriate.***

Smoking and Lung Cancer Screening (if applicable)/ACE & ARB

**32. Do you currently smoke cigarettes every day, some days, or not at all?** (Circle one number)

1. Every day
2. Some days
3. Not at all → ***go to question 37***

**Lung CA eligibility if:**
- ≥ 55 years and
- current smoker and
- smoking pack years ≥ 30

**33. On average, how many cigarettes do you currently smoke <u>each day</u>?** (Write the number in the space below)

Number of cigarettes smoked daily: _____

**34. How long have you smoked cigarettes?** (Write the length of time in the space below)

_____ years +_____months.

**Smoking Pack Years:**

**Positive screen for lung CA?:**

**35. Please indicate how prepared you are to decrease the number of cigarettes you currently smoke.** Where 0 = not prepared to decrease and 10 = already decreasing. (Circle one number)

**<u>How prepared</u>**

| **0** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not prepared to decrease** | | | | | | | | | | **Already decreasing** |



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**36. How confident are you that you can decrease the number of cigarettes you currently smoke?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

**How confident**

| **0** | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not at all confident** | | | | | | | | | | **Extremely confident** |

→ ***go to question 41***

Smoking and Lung Cancer Screening (if applicable)/ACE & ARB

**37. Have you ever smoked cigarettes regularly, that is, at least one cigarette per day?** (Circle one number)

1. Yes
2. No → ***go to question 41***

**Lung CA eligibility if:**
- ≥ 55 years and
- quit < 15 years and
- smoking pack years ≥ 30

**38. On average, how many cigarettes did you smoke <u>each day</u> when you were smoking?** (Write the number in the space below)

Number of cigarettes smoked daily: _____

**39. How long did you smoke cigarettes?** (Write the length of time in the space below)

_____ years +_____months

**40. How long ago did you stop smoking cigarettes completely?** (Write the length of time in the space below)

_____ years +_____months

**Smoking Pack Years:**

**Positive screen for lung CA?:**



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Q41 – 42: Physical Activity GPPAQ Score

**41. Please tell us the type and amount of physical activity involved in your work.**[1] (Circle one number)

1. I am not employed (for example: retired, retired for health reasons, unemployed, full-time carer, etc.).
2. I spend most of my time at work sitting (such as in an office).
3. I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (for example: shop assistant, hairdresser, security guard, child care provider, etc.).
4. My work involves definite physical effort including handling of heavy objects and use of tools (for example: plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers, etc.).
5. My work involves vigorous physical activity including handling of very heavy objects (for example: scaffolder, construction worker, refuse collector, etc.).

**42. During the last week, please indicate with an "x" how many hours you spent on each of the following activities.** Please answer the questions even if you are not employed.

| | None | Some, but less than 1 hour | 1 hour, but less than 3 hours | 3 hours or more |
|---|---|---|---|---|
| a) Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout, etc. | X | | | |
| b) Cycling, including to work and during leisure time | X | | | |
| c) Walking, including walking to work, shopping, for pleasure, etc. | | | | X |
| d) Housework/Childcare | | | X | |
| e) Gardening/Do-it-yourself projects | X | | | |

[1] Physical activity questions are the General Practice Physical Activity Questionnaire (GPPAQ).
Heron N, Tully MA, McKinley MC, Cupples ME. Physical activity assessment in practice: a mixed methods study of GPPAQ use in primary care. BMC Family Practice. 2014; 15:11.



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Physical Activity

**43. How would you describe your usual walking pace?** (Circle one number)

(1.) Slow pace
2. Steady average pace
3. Brisk pace
4. Fast pace

**Active** if ≥ 150 mins/week
**Inactive** if < 150 mins/week

**GPPAQ Score:** Inactive

**Eligible to improve physical activity?**

**44. Please indicate how prepared you are to increase the amount of physical activity you currently do.** Where 0 = not prepared to increase and 10 = already increasing. (Circle one number)

**How prepared**

| **0** | 1 | 2 | 3 | (4) | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not prepared to increase** | | | | | | | | | | **Already increasing** |

**45. How confident are you that you can increase the amount of physical activity you currently do?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

**How confident**

| **0** | 1 | 2 | 3 | (4) | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not at all confident** | | | | | | | | | | **Extremely confident** |

**46. In general, how would you rate your eating habits?** (Circle one number)

1. Excellent
(2.) Very Good
3. Good
4. Fair
5. Poor



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Q47a-n: Mediterranean Diet Screen

**47. Please tell us about your eating habits[2]:**

**47a. Is olive oil the main source of fat for cooking?** (Circle one number)

1. Yes
2. No

**47b. Do you have 4 tablespoons (60 ml) or more of olive oil each day?** (Circle one number)

1. Yes
2. No

**47c. Do you eat 4 servings of vegetables each day?** *1 serving is ½ cup raw or cooked or 1 cup of raw salad greens.* (Circle one number)

1. Yes
2. No

**47d. Do you have 3 whole fruits or 1.5 cups of fruit each day?** (Circle one number)

1. Yes
2. No

**47e. Do you eat less than 1 serving of red meat, hamburger, sausage or processed meats daily?** (Circle one number)

1. Yes
2. No

**47f. Do you eat 1 tablespoon (15 ml) or less of butter, margarine or cream each day?** (Circle one number)

1. Yes
2. No

**Mediterranean diet - Medi-Tool:**
"Yes" answers indicate areas where a patient is making healthy choices.

[2] Adapted from the Mediterranean Diet Score Tool + Adherence Screener.
Dietitians of Canada. Mediterranean Diet Toolkit: Supporting Patients to Reduce CVD Risk and Improve Mental Health. November 2018. www.dietitians.ca



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Q47a-n: Mediterranean Diet Screen

**47g. Do you have less than 1 can (355 ml or 12 oz) of sugar sweetened beverages each day?** (Circle one number)

1. Yes
2. No

**47h. Do you drink 3 glasses or more of wine per week?** *1 serving is 150 ml or 5 oz*. (Circle one number)

1. Yes
2. No

**Answer exception!** Medi-tool considers a "No" as an item to potentially change. **Do not recommend drinking alcohol**. Follow the recommendations as per the Care Map.

**47i. Do you have 3 servings or more of legumes (peas, beans, or lentils) each week?** *1 serving is half a cup to two-thirds of a cup.* (Circle one number)

1. Yes
2. No

**47j. Do you have 3 servings or more of fish or seafood each week?** *One fish serving is 3.5-5 oz or 100-150 g. One seafood serving 4-5 pieces.* (Circle one number)

1. Yes
2. No

**47k. Do you eat commercial baked goods such as cookies, doughnuts or cake less than 2 times per week?** (Circle one number)

1. Yes
2. No

**47l. Do you eat nuts 3 or more times per week?** 1 serving is 30 g or 1 oz. (Circle one number)

1. Yes
2. No

**47m. Do you choose chicken or turkey more often than beef, pork, hamburger or sausage?** (Circle one number)

1. Yes
2. No



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Q47a-n: Mediterranean Diet Screen

**47n. Do you consume vegetables, pasta or rice dishes with a homemade sauce of sautéed garlic, onions, olive oil and tomatoes 2 or more times a week?** (Circle one number)

1. Yes
2. No

**Eligible to improve diet if:**
At least 2 items can be improved. That is, at least 2 answers are "No" (not including Q47h)

**Eligible to improve diet?**

**48. Please circle the number that shows how prepared you are to improve your current diet.** Where 0 = not prepared to improve and 10 = already improving. (Circle one number)

**How prepared**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not prepared to improve** | | | | | | | | | | **Already improving** |

**49. How confident are you that you could improve your current diet?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

**How confident**

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not at all confident** | | | | | | | | | | **Extremely confident** |

**50. During the past 12 months, have you had any drinks containing alcohol?** (Circle one number)

1. Yes
2. No → ***go to Section G (page 22)***

Alcohol

**51. On average, how many drinks containing alcohol do you currently have <u>each week</u>?** *A drink is defined as a 341 ml (12 oz.) glass containing 5% alcohol (beer, cider or cooler), a 142 ml (5 oz.) glass of wine with 12% alcohol content, or a 43 ml (1.5 oz.) shot/serving of 40% distilled alcohol content (rye, gin, rum, etc.).* (Write the number in the space below)

Number of drinks containing alcohol you have weekly: 6

**Positive screen if:**
- Men >14 drinks/week
- Females >7 drinks/week

**Screen positive?:**



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Alcohol

**52. How many drinks containing alcohol do you have on a typical day when you are drinking?** (Circle one number)

Provides information about alcohol consumption on a typical day.

1. 1
2. 2
3. (3) 3
4. 4
5. 5
6. 6
7. 7
8. 8
9. 9
10. 10 or more

**53. MEN: How often do you have 5 or more drinks containing alcohol on one occasion?** (Circle one number)

**WOMEN: How often do you have 4 or more drinks containing alcohol on one occasion?** (Circle one number)

1. (1) Never → - screen
2. Less than monthly → + screen
3. Monthly → + screen
4. Weekly → + screen
5. Daily or almost daily → + screen

**Positive screen for binge drinking if:**
- Men ≥ 5 drinks at any frequency other than never
- Females ≥4 drinks at any frequency other than never

**Screen positive for binge drinking?:**

**54. Please indicate how prepared you are to reduce the amount of alcohol you currently drink.** Where 0 = not prepared to reduce and 10 = already reducing. (Circle one number)

**How prepared**

| **0** | 1 | (2) | 3 | 4 | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not prepared to reduce** | | | | | | | | | | **Already reducing** |



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**55. How confident are you that you could reduce the amount of alcohol you currently drink?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

**How confident**

| **0** | (1) | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | **10** |
|---|---|---|---|---|---|---|---|---|---|---|
| **Not at all confident** | | | | | | | | | | **Extremely confident** |

## SECTION G: GENERAL HEALTH

***Instructions: These questions are for both men and women.***

***These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.***

***Please circle the number that you think best describes how you feel. If you are unsure about how to answer a question, please give the best answer you can.***

**56. In general, would you say your health is:** (Circle one number)

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor



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PHQ2 – Depression Screen

**57. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?**[3]

**57a. Little interest or pleasure in doing things** (Circle one number)

| | | |
|---|---|---|
| 1. | Not at all | → 0 points |
| (2.) | Several days | → 1 |
| 3. | More than half the days | → 2 |
| 4. | Nearly every day | → 3 |

**57b. Feeling down, depressed or hopeless** (Circle one number)

| | | |
|---|---|---|
| 1. | Not at all | → 0 points |
| (2.) | Several days | → 1 |
| 3. | More than half the days | → 2 |
| 4. | Nearly every day | → 3 |

| |
|---|
| **Positive PHQ2 screen if Q57a + Q57b** ≥ 3 points |
| **Total points:** |
| **Positive PHQ-2 screen?:** |

[3] The Patient Health Questionnaire – 2 (PHQ-2).
Kroenke K, Spitzer L, Williams JBW. The Patient Health Questionnaire – 2: Validity of a two-item depression screener. Medical Care. 2003; 41:11.



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## SECTION H: FAMILY MEDICAL HISTORY

***Instructions: These questions are for both men and women.***

***Knowing your family history can help your health care practitioners provide better care for you.***

Family History and QRISK2

**58. The 2 tables below list some chronic diseases. Please complete the 2 tables to the best of your knowledge.**

*For each of the following, please only include relatives that are related to you by **blood or birth** and do not include relatives related to you by marriage.*

*If one or more of your blood relatives has been diagnosed with the disease, please indicate the age of the relative who was diagnosed the youngest. For example, if your sister was diagnosed with diabetes at age 20 and your brother was also diagnosed with diabetes at age 35, you would write "20" under youngest age at diagnosis.*

*If you are not sure at what age someone was diagnosed, please use your best guess for the age.*

| | **First Degree Relatives** | | | | | |
|---|---|---|---|---|---|---|
| **Chronic Diseases** | **Your Parents** | | **Your Brothers or Sisters** | | **Your Children** | |
| | Number of parents with disease | Youngest age at diagnosis | Total number of brothers or sisters with disease | Youngest age at diagnosis | Total number of children with disease | Youngest age at diagnosis |
| Diabetes | 1 | 59 | | | | |
| Breast Cancer | | | | | | |
| Colorectal (Bowel) Cancer | | | | | | |
| Pancreatic Cancer | | | | | | |
| Ovarian Cancer | 1 | 78 | | | | |
| Prostate Cancer | | | | | | |
| Angina/Heart Attack | | | | | | |



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Family History

| | Second Degree Relatives<br>*Uncles, Aunts, Nieces, Nephews and Grandparents* | | | |
|---|---|---|---|---|
| **Chronic Diseases** | **On Your Mother's Side** | | **On Your Father's Side** | |
| | Total number of relatives with disease | Youngest age at diagnosis | Total number of relatives with disease | Youngest age at diagnosis |
| Diabetes | | | | |
| Breast Cancer | | | | |
| Colorectal (Bowel) Cancer | 1 | 66 | 1 | 75 |
| Pancreatic Cancer | | | | |
| Ovarian Cancer | | | | |
| Prostate Cancer | | | | |
| Angina/Heart Attack | 2 | 60 | | |

**59. If you indicated that one or more of your first or second degree relatives had breast cancer, were any of those relatives male?** (Circle one number)

1. Yes
2. No
3. Not Applicable

## SECTION I: ABOUT YOU

***Instructions: These questions are for both men and women.***

***For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.***

**60. Were you born in Canada?** (Circle one number)

1. Yes → ***go to question 62***
2. No



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**61.** **In what year did you first come to Canada to live?** (Write the year in the space below)

1960
(year) e.g. 1987

**62.** **What were the ethnic or cultural origins of your ancestors?** *An ancestor is usually more distant than a grandparent.* (Please write as many origins as needed in the space below)

_____

_____

Waist Circumference/Diabetes/Breast Cancer/QRISK2

**63.** Your ethnic and cultural background helps determine your risk for cancer and other chronic diseases**.** Some groups are known to be at higher risk. The list below will help us determine if YOU are at higher risk for chronic diseases.

**Please tell us if any of the following describe your ethnic or cultural background.** (Circle all that apply)

1. Indigenous → ***go to question 63a.***
2. African-Caribbean
3. Ashkenazi Jewish
4. Bangladeshi
5. Black African
6. Central American (e.g. Costa Rican, Guatemalan, etc.)
7. Chinese
8. East Indian
9. Icelandic
10. Japanese
11. Pakistani
12. South American (e.g. Brazilian, Chilean, Colombian, etc.)
13. South Asian (e.g. Afghan, Sri Lankan, etc., not including East Indian or Pakistani)
14. None

**Elevated risk due to ethnicity?:**



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**63a.** **If you are an Indigenous person, please identify your Indigenous group.** (Circle all that apply)

1. Inuk or Inuit
2. Métis
3. First Nations (North American Indian) includes Status and Non-Status Indians
4. Other (Please specify):_____

**64.** **What is your marital status?** Please circle the number of the status that best describes your current situation. (Circle one number)

1. Married
2. Common-law
3. Divorced (not living common-law)
4. Widowed (not living common-law)
5. Separated (not living common-law)
6. Single or never married

**65.** **If there is anything else that you would like to comment on, or feel is important to include, please feel free to write in the space below**.

_____

_____

_____

_____

_____

***THANK YOU for completing the BETTER Health Survey™!***

***Please return your survey to your healthcare provider.***



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# Case Example – Patient Z ♠ – Medical Chart

- Height is 158 cm
- Weight is 73 kg
    - BMI is 29.2 kg/$m^2$
- Waist circumference is 83 cm
- BP is 135/70
- Lab results as of Jan 01, 2000 (today)
    - HbA1c 6.1%,
    - Total cholesterol 3.5 mmol/L
    - HDL 1.5 mmol/L
    - LDL 2.0 mmol/L
- QRISK2 10-year cardiovascular risk 2.1 %
- No FOBT/FIT results in chart
- PAP last done January 1996 – normal results
- No mammogram results in chart
- No HTN medications in chart

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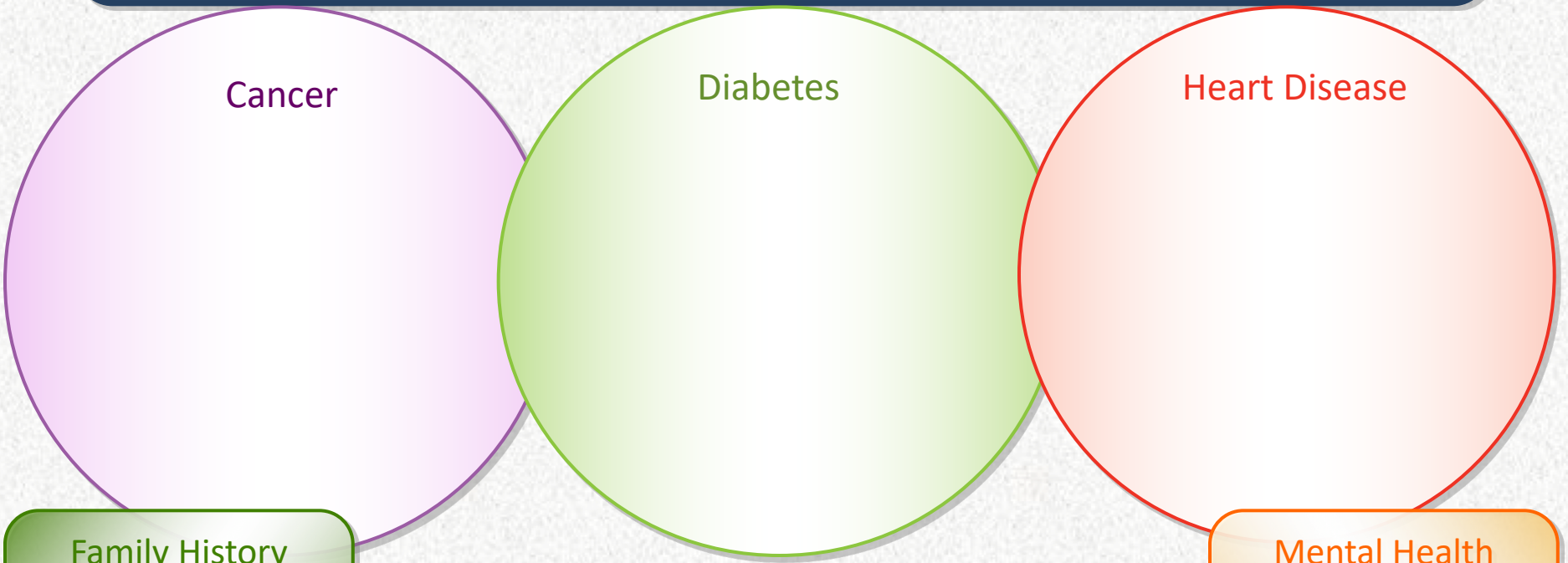
Areas we will focus on during your prevention visit




Family History

Mental Health

# Primary Prevention

Nutrition

Physical Activity

Alcohol

Smoking

**Factors that Determine Your Risk for Chronic Disease**

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Date:_____ Name :_____

## Your Health Care Team and You Working Together:
## THE PREVENTION PRESCRIPTION

At your visit, we worked together to identify a number of important actions you can take to help prevent chronic disease. **This tool can be used to increase your understanding of the recommended guidelines for regular screening around some of the following potential lifestyle concerns and chronic diseases. Together, we can take steps to support and improve your health and well-being!**

| Screening For: | Status/Results | Target | Re-Check | Referrals/Actions |
|---|---|---|---|---|
| ***Cardiovascular Disease*** | Enter measurement value or lab value | | Enter year or time frame | Enter referrals made or action items for patient or clinician |
| BMI | $kg/m^2$ | 18.5 – 24.9 $kg/m^2$ | | |
| WC | cm | Males < 102 cm<br>Females < 88cm | | |
| Blood pressure | / | Diab < 130/80<br>Non-Diab < 140/90 | | |
| Risk Assessment | % | Every 3 years* | | |
| ACE/ARB criteria** | | | | |
| ***Diabetes*** | FBS mmol/L or HbA1c% | | Enter year or time frame | Enter referrals made or action items for patient or clinician |
| FBS/HbA1c | | FBS <6mmol/L<br>HbA1c <6.0% | | |
| ***Cancer Screening*** | Enter month and year of last test | | Enter year or time frame | |
| FOBT/FIT | | Every 2 years* | | |
| Sigmoidoscopy | | Every 10 years* | | |
| Colonoscopy | | Every 10 years* | | |
| Pap test | | Every 3 years* | | |
| Mammogram | | Every 2 years* | | |
| Lung | | | | |
| ***Lifestyle and Other Concerns**** | | | Enter year or time frame | Enter referrals made or action items for patient or clinician |
| Physical activity | | ≥ 150 mins/week, limit sitting or lying down for long periods | | |
| Diet | | Fruits & vegetables (7-10 servings/day), low salt, limit fat & sugar | | |
| Alcohol | | M ≤ 14 drinks/week<br>F ≤ 7 drinks/week | | |
| Smoking | | Quit/Reduce | | |
| Depressed mood | | | | |
| | | | | |

**Family history of cardiovascular disease****: Yes ◯ /No ◯ /NA ◯ /Unknown ◯

**Personal history of cardiovascular disease****: Yes ◯ /No ◯ /NA ◯ /Unknown ◯

**Patient has possible elevated risk for****:

1. Diabetes: Yes ◯ /No ◯ /NA ◯ /Unknown ◯
2. Breast cancer: Yes ◯ /No ◯ /NA ◯ /Unknown ◯
3. Cervical cancer: Yes ◯ /No ◯ /NA ◯ /Unknown ◯
4. Colorectal cancer: Yes ◯ /No ◯ /NA ◯ /Unknown ◯

*These are normal screening intervals. Review patient risk status to determine if they are at elevated risk.

**Pre-populated information is based on patient self-report. Review patient information.

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