

Patient: _____

DIABETES VISIT WORKSHEET

Office visit date: _____

Provider this visit: _____

PCP/Medical Home: _____

Birth date: _____ Age: _____

Gender: M F U

Diabetes	Diabetes: <input type="radio"/> Type 1 <input type="radio"/> Type 2	Comorbidities	<input type="checkbox"/> CAD	<input type="checkbox"/> Hypertension
	Year of first diagnosis: _____		<input type="checkbox"/> PVD	<input type="checkbox"/> Renal Failure/Proteinuria
Patient Goals	Blood pressure: _____		Functional goal:	
	Weight: _____		e.g., "Walk to grocery store"	
	HbA1c: _____		Home blood glucose monitoring?:	
		e.g., Only able to test twice a week due to cost of strips		

Blood Pressure

Recommended blood pressure target < 130/80.

Blood pressure: _____ / _____ Weight: _____

PAST READINGS	Date	BP	Weight	BMI	Height:

HbA1c

Recommended HbA1c target < 7.0.

Date	Result	Lab
MORE RECENT VALUE? _____		

Cholesterol

Recommended LDL target < 100 and triglycerides target < 150. If diabetes and cardiovascular disease LDL < 70.

Date	TC	LDL	TG	HDL	Lab
MORE RECENT VALUES? _____					

Microalbuminuria	ⓘ Recommend microalbuminuria test at least once annually.		
	LAST TEST	Results: _____	Lab: _____
	MORE RECENT TEST? _____		

Aspirin	ⓘ Recommend taking at least 81 mg of aspirin a day unless contraindicated.		
	Is patient using Aspirin?	<input type="radio"/> Yes	<input type="radio"/> No

ACE/ARB	ⓘ Consider Ace Inhibitor if hypertension or proteinuria is present.		
	Is patient using ACE inhibitor?	<input type="radio"/> Yes	<input type="radio"/> No

Beta Blockers	ⓘ If history of myocardial infarction, beta blocker is recommended unless contraindicated.			
	Is patient using beta blocker?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Contraindicated
	✓ Patient on beta blocker. Confirm use.			

Depression	ⓘ Recommend asking patient two screening questions.		
	1) During the past month have you often been bothered by feeling down, depressed or hopeless?	<input type="radio"/> Yes	<input type="radio"/> No
	2) During the past month have you often little interest or pleasure in doing things?	<input type="radio"/> Yes	<input type="radio"/> No
	INTERVENTION		
	<input type="checkbox"/> Ongoing counseling	<input type="checkbox"/> On anti-depressant meds	<input type="checkbox"/> Referred counseling

Retinal	ⓘ Recommended annually for Type 2 diabetes and after 5 years for Type 1 diabetes.		
	<input type="checkbox"/> Referred for retinal exam this visit?	_____	
		Provider's name	
	LAST EXAM RECORDED	Date: _____	Provider: _____
MORE RECENT EXAM? _____			

