



# VISIT WORKSHEET SUMMARY

- COMORBIDITIES**
- |   |  |
|---|--|
| <input type="checkbox"/> CAD                        | <input type="checkbox"/> Hypertension              |
| <input type="checkbox"/> PVD                        | <input type="checkbox"/> Renal Failure/Proteinuria |
| <input type="checkbox"/> Foot Ulceration/Amputation | <input type="checkbox"/> Retinal disease           |
| <input type="checkbox"/> TIA/Stroke/CVD             | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Peripheral neuropathy      | <input type="checkbox"/> None                      |

Place patient label here

Today's date \_\_\_\_\_

Diabetes \_\_\_\_\_

Dx year \_\_\_\_\_

**VITALS**

*Last Visit*

BP \_\_\_\_\_

Pulse \_\_\_\_\_

Weight \_\_\_\_\_

Height \_\_\_\_\_

BMI \_\_\_\_\_

**PHYSICAL EXAM**

	<i>N</i>	<i>NE</i>	<i>Ab</i>	<i>Comments</i>
Fundi	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oral Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
COR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Foot Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shape	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Nails	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

	<i>Yes</i>	<i>No</i>
Smoking?	<input type="radio"/>	<input type="radio"/>
Check feet daily?	<input type="radio"/>	<input type="radio"/>
Glucose monitoring?	<input type="radio"/>	<input type="radio"/>
S/Sx Hypoglycemia?	<input type="radio"/>	<input type="radio"/>
S/Sx Hyperglycemia?	<input type="radio"/>	<input type="radio"/>

In last month:

Feeling down, depressed or hopeless?

Often little interest or pleasure in doing things?

*Assessment Plan:*

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*History since last visit & Self Management Goals:*

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	<i>Yes</i>	<i>No</i>	<i>Contraindicated</i>
Aspirin?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Beta Blocker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
ACE/ARB?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**INSTRUCT**

<input type="checkbox"/> Foot Care	<input type="checkbox"/> Diabetes & CAD
<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Diet and Exercise

Other \_\_\_\_\_

**CURRENT MEDS**

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**REFERRALS**

*Doctor*

Ophthalmology \_\_\_\_\_

Podiatry \_\_\_\_\_

Cardiology \_\_\_\_\_

Diabetes Health Ed     WATS     DSCH     SUTTER

Other \_\_\_\_\_

**LABS**

	<i>TC</i>	<i>LDL</i>	<i>TG</i>	<i>HDL</i>
Cholesterol	_____	_____	_____	_____
(Date)	_____	_____	_____	_____
HgbA1c	<i>Result</i>			
(Date)	_____			
Microalbuminuria	_____			
(Date)	_____			

	<i>Last</i>	<i>Given today</i>
Flu Shot	_____	<input type="checkbox"/>
Pneumovax	_____	<input type="checkbox"/>