

Place patient label here

Today's date _____

VISIT WORKSHEET SUMMARY

Diabetes _____

Dx year _____

- | | | |
|----------------------|---|--|
| 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 |

Last Visit

VITALS	BP _____
	Pulse _____
	Weight _____
	Height _____
	BMI _____

	<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?

History since last visit & Self Management Goals:

	<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"/>

CURRENT MEDS

Cholesterol	<i>TC</i>	<i>LDL</i>	<i>TG</i>	<i>HDL</i>
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(Date)

HgbA1c _____ *Result*

(Date)

Microalbuminuria _____ *Result*

(Date)

LABS

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"/>	
	<i>Pulses</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Sensation</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Shape</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Color</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Lesions</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<i>Edema</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<i>Nails</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Assessment Plan:

ORDERS

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

REFERRALS	<input type="checkbox"/> Retinal screening _____
	<input type="checkbox"/> Podiatry _____
	<input type="checkbox"/> Cardiology _____
	<input type="checkbox"/> Diabetes Health Ed <input type="checkbox"/> WATS <input type="checkbox"/> DSCH <input type="checkbox"/> SUTTER
Other _____	

Today

Flu Shot _____

Pneumovax _____

Return visit _____

Provider's Signature _____

(Title)

(Date)