

Diabetes care patient notes: Part 1

Use the form below to track and assess patient progress. You may wish to retain this form in the progress notes section of the patient's medical chart.

Patient name: _____

Date: _____ Medical Record #: _____

Male Female Tobacco use: Yes No A1C: _____ mg/dL

Preprandial glucose: _____ mg/dL

Lipid: Total _____ mg/dL LDL _____ HDL _____ Triglycerides _____

Medications: _____

Vital Signs

WT: _____ RR: _____

HT: _____ BP: _____

HR: _____ Temp: _____

Physical Exam

Head and neck: _____

Lungs: _____

Heart: _____

Abdomen: _____

Extremities: _____

Neuro: _____

Other (e.g., eye, dental): _____

Foot Exam Test Areas



Indicate
Presence (+)
or Absence (-)
of sensation in
5 areas using
10-gram
monofilament

Right Foot

Left Foot

Patient assessment — follow up as necessary (Check best answer)

Have you visited an emergency room or urgent care office or been admitted to the hospital for treatment of diabetes problems since your last visit? No Yes

How many times a day do you test your blood sugar with your meter? 1 2 or more

Do you have any trouble telling when you have low blood sugar? No Yes

How many times per week do you have low blood sugar during the day? 0 1 or more

How many times per week do you have low blood sugar at night? 0 1 or more

Do you have any problems with your medicines? No Yes

Have you noticed any problems with your eyes, feet, or skin since your last visit? No Yes

Other: _____

Do you ever have: Chest pain Claudication Foot ulcers/rashes Urinary tract symptoms

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Diabetes care patient notes: Part 2

Patient assessment — follow up as necessary (Check or fill in best answer)

- Do you follow a regular, written meal plan? No Yes
- Do you usually read food labels when you shop at the grocery store? No Yes
- Do you add sugar or salt to your food when you cook or eat? No Yes
- How many servings of vegetables do you eat on an average day? 0 _____
- How many servings of fruit do you eat on an average day? 0 _____
- What kind of physical activity do you get? _____
- How many times a day do you get physical activity? 0 1 or more
- How long does each period of physical activity usually last? _____ Min.
- Do you ever have to treat for low blood sugar after being active? No Yes
- How many cigarettes do you smoke on an average day? 0 1 or more
- Do you ever feel depressed? No Yes

Other: _____

Knowledge assessment — check appropriate box

- Meter technique Satisfactory Unsatisfactory Refer for Diabetes Self-Management Training
- Diabetes understanding Satisfactory Unsatisfactory Refer for Diabetes Self-Management Training
- Balanced meal plan Satisfactory Unsatisfactory Refer for nutrition education
- Exercise plan Satisfactory Unsatisfactory Refer for exercise physiologist
- Does current treatment require adjustment? No Yes

If yes, action taken: _____

Treatment plan

Influenza vaccine Pneumococcal vaccine Schedule tests

Provide education sheets Refer to specialist: _____

Adjust diabetes care plan (medications, diet, exercise) as needed and record changes: _____

Next visit 1 2 3 4 5 6

Days Weeks Months

Provider Name/Signature: _____

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