Bar Code

Date:		Time:	Clinician:		MA/Nurse Signature:		
VS	Wt:	T:	P:	R:	BP: /	Age:	Smoker: Y N
Allergies:					LMP:		Pain scale:
Reasons for visit:			Other concerns *(specify)*:				

HPI:

FOLLOW-UP ON GOAL FROM PREVIOUS VISIT:

HOME GLUCOSE RESULTS:	PHYSICAL ACTIVITY:
DIET ADHERENCE:	MEDICATION ADHERENCE:
MOOD/SOCIAL SUPPORT:	Please document reasons for non-adherence:

PMH:

REVIEW OF SYSTEMS

Blurred Vision	Y	N	TIA symptoms	Y	N	**Medications:**	
Chest pain	Y	N	Shortness of breath	Y	N	☐ ASA	
Numbness/Tingling	Y	N	Blacking out	Y	N		
Hypoglycemia	Y	N	Racing heart	Y	N		
Foot sores	Y	N	Swelling feet & ankles	Y	N		
Nausea/Vomiting/Diarrhea	Y	N	Sexual dysfunction	Y	N		

PHYSICAL EXAM *(blank = not examined)*

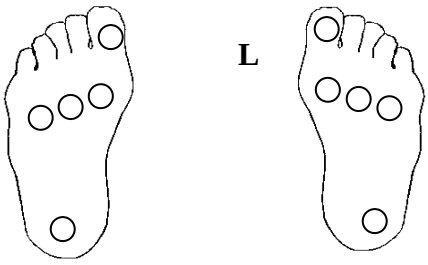
GENERAL	Norm	AbN	NEUROLOGIC	Norm	AbN
HEENT/CAROTIDS	Norm	AbN	SKIN	Norm	AbN
HEART	Norm	AbN	LEGS-EDEMA/ INDURATION/DERMATITIS	Norm	AbN
LUNGS	Norm	AbN			
ABDOMEN	Norm	AbN	OTHER	Norm	AbN

FOOT EXAM: Deformities *(indicate location)*

Ulcers	Y	N	
Calluses	Y	N	
Swelling	Y	N	
Thickened toenails	Y	N	
Toe deformity	Y	N	
Onychomycosis	Y	N	
Pedal pulses	0	1+	2+
COMMENTS:			

(–) Cannot feel the monofilament (+) Can feel the monofilament

R **L**



Clinician's Signature **Date**

PATIENT IDENTIFICATION

Name:

MR#

Loma Linda University Health Care
Family Medical Group
DIABETES CARE FORM
Created 03/05 Revised 1/06

Bar Code

Date:

MOST RECENT TESTS RESULTS REVIEWED W/ PT:		
☐ Y ☐ N A1C	☐ Y ☐ N MICROALBUMIN	☐ Y ☐ N RETINAL EYE EXAM
☐ Y ☐ N LIPIDS	☐ Y ☐ N BUN/CREAT	☐ Y ☐ N OTHER *(specify)*:

ASSESSMENT

1.	4.
2.	5.
3.	6.

REFERRALS ☐ **No Referral Needed**

☐ Y Dental Exam	☐ Y Podiatry
☐ Y Diabetes Treatment Center	☐ Y Ophthalmology
☐ Y Cardiology	☐ Y Other Referral *(specify)*:

D = Discussed/Education Given **H** = Handouts Given

☐ D ☐ H Nutrition Counseling	☐ D ☐ H BS Monitoring	☐ D ☐ H Counseled Re-Smoking Cessation
☐ D ☐ H Foot Care	☐ D ☐ H Weight Management	☐ D ☐ H Insulin Management
☐ D ☐ H Exercise	☐ D ☐ H Medication Adherence	☐ D ☐ H Importance of Annual Eye Exam

PLAN:

LAB STICKER

LABS:

Patient's Goal for next visit:

F/U with PCP:

Clinician's Signature **Date**

DIAGNOSES		250.__0	Type II Controlled	250.__2	Type II Uncontrolled
4th Digits:					
250.6__	Neuropathy	250.5__	Retinopathy	250.0__	No complications
250.4__	Nephropathy	250.8__	Hypoglycemia/Ulcerations		
272.0	Pure Hypercholesterolemia	272.1	Pure Hypertriglyceridemia	278.01	Morbid Obesity
272.2	Mixed Hyperlipidemia	272.4	Hyperlipidemia Unspecified	250.__1	Type I Controlled
401.1	HTN	110.1	Onychomycosis	250.__3	Type I Uncontrolled

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DIABETES CARE FORM

Created 03/05

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