

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

This material has been developed by GlaxoSmithKline.

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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you usually read food labels when you shop at the grocery store?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you add sugar or salt to your food when you cook or eat?	<input type="checkbox"/> No <input type="checkbox"/> Yes
How many servings of vegetables do you eat on an average day?	<input type="checkbox"/> 0 _____
How many servings of fruit do you eat on an average day?	<input type="checkbox"/> 0 _____
What kind of physical activity do you get?	_____
How many times a day do you get physical activity?	<input type="checkbox"/> 0 <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
How many cigarettes do you smoke on an average day?	<input type="checkbox"/> 0 <input type="checkbox"/> 1 or more
Do you ever feel depressed?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other: _____	

Knowledge assessment — check appropriate box
Meter technique <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refer for Diabetes Self-Management Training
Diabetes understanding <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refer for Diabetes Self-Management Training
Balanced meal plan <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refer for nutrition education
Exercise plan <input type="checkbox"/> Satisfactory <input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Refer for exercise physiologist
Does current treatment require adjustment? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, action taken: _____

Treatment plan
<input type="checkbox"/> Influenza vaccine <input type="checkbox"/> Pneumococcal vaccine <input type="checkbox"/> Schedule tests
<input type="checkbox"/> Provide education sheets <input type="checkbox"/> 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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