


















**Diagnosis**

**Yes**  
(Mark an X)

**Year  
Diagnosed**

 <b>Diabetes</b>		
 <b>Gestational Diabetes</b>		
 <b>Neuropathy</b>		
 <b>Hypertension</b>		
 <b>IHD/Myocardial Infarction</b>		
 <b>Nephropathy</b>		
 <b>High Cholesterol</b>		
 <b>Stroke</b>		
 <b>Diabetic Foot</b>		
 <b>Retinopathy</b>		
 <b>Amputation</b>		
 <b>Depression</b>		
 <b>Cancer</b>		
 <b>Chronic Respiratory Disease</b>		
 <b>Other (specify)</b>		



## MEDICAL VISITS

### Checkpoint

### Goal

### How Often?

Blood Pressure (mmHg)

Diabetes: <130/80  
Hypertension only: <140/90

Every Visit

BMI

BMI <25 Kg/m<sup>2</sup>

Every Visit

Weight (Kg/Lbs) Height (ins/cm)

Every Visit

Waist Circumference

F: <80 cm (32"); M: <94 cm (37")

Every Visit

Brief Foot Exam

Normal. Remove shoes/socks

Every Visit

Complete Foot Exam

Clinical exam

Annual

Eye Exam A/N\*

Normal

Yearly

Cardiovascular Risk

<10%

Each Visit

Fasting

4-6 Plasma/Capillary

Yearly

2hrPP

4-8 Plasma/4-7 Capillary

As Needed

Hemoglobin A1c

<6.5%

2 Per Year (4X Per Year if > 8%)

HDL

F: >1.0; M>1.3

Yearly

LDL

F: <2.6; M<2.6

Yearly

Triglyceride

F: <1.7; M<1.7

Yearly

Urine Microalbumin

<30 ug/mg Creatinine

Yearly

Urine Dipstick

Normal (Dipstick if available)

Every Visit

ECG A/N\*

Normal

Yearly

BUN/Creatinine

Yearly

Sodium/Potassium

As Needed

Dental Review A/N\*

Normal

Every 6 Months

Nutrition Review +/-

As recommended

Every Visit

Depression Screen +/-

None

Every Visit

Hospitalization (Date)

None

Date

Patient Education +/-

Every Visit

Exercise Prescription

As recommended

Every Visit

Smoking(+/-)/Alcohol (+/-)

Do not use

Every Visit

\*A/N - abnormal/normal



*Patient Goal*

*Date*  
DD/MM/YYYY

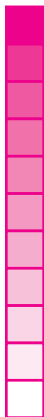
*Date*  
DD/MM/YYYY

*Date*  
DD/MM/YYYY

*Date*  
DD/MM/YYYY

*Date*  
DD/MM/YYYY

*Date*  
DD/MM/YYYY





## MEDICAL VISITS



### Checkpoint

Date  
MM/DD/YYYY

Date  
MM/DD/YYYY

Date  
MM/DD/YYYY

Date  
MM/DD/YYYY

Date  
MM/DD/YYYY

Blood Pressure (mmHg)

BMI

Weight (Kg/Lbs) Height (ins/cm)

Waist Circumference

Brief Foot Exam

Complete Foot Exam

Eye Exam A/N

Cardiovascular Risk

Fasting

2hrPP

Hemoglobin A1c

HDL

LDL

Triglyceride

Urine Microalbumin

Urine

ECG A/N

BUN/Creatine

Sodium/Potassium

Dental Review A/N

Nutrition Review +/-

Depression Screen +/-

Hospitalization (Date)

Patient Education +/-

Exercise Prescription

Smoking(+/-)/Alcohol (+/-)



## LABORATORY



## EDUCATION