

Family Medicine Clerkship Chart Review

Student Name: _____

Clerkship Site: _____

You are to review the charts of 3 patients you have seen who have been diagnosed with diabetes mellitus and fill in all appropriate information on these patients that applies for the past 12 months.
(see example listed)

Age	Gender	DM diagnosis in PMH? (Yes or No)	A1C value (Date)	ACEi or ARB? (Yes or No)	Lipids value (Date)	Blood Pressure (Date)	Dilated Retinal Exam	Microalbumin (Date)	Flu Vaccine in the last 12 months?	Complete Foot Exam	Does the chart recommend Aspirin Therapy (dose ≥ 75 mg)	Is the Patient a smoker?	Has the patient been counseled to stop smoking?
60	M	Yes: <u> X </u> No: _____	8.3 (9/4/2012)	Yes: <u> X </u> No: _____	Date: <u> 4/4/12 </u> Total Cholesterol: <u> 245 </u> LDL : <u> 170 </u> HDL: <u> 75 </u> Triglyceride: <u> 65 </u>	Date: <u> 4/4/12 </u> Systolic: <u> 171 </u> Diastolic: <u> 78 </u>	Yes: _____ No: _____ Unknown: <u> X </u>	Date: _____ Yes: _____ No: <u> X </u>	Yes: <u> X </u> No: _____	Yes: <u> X </u> No: _____ N/A: _____	Yes: _____ No: <u> X </u> N/A: _____	Yes: <u> X </u> No: _____	Yes: <u> X </u> No: _____
		Yes: _____ No: _____		Yes: _____ No: _____	Date: _____ Total Cholesterol: _____ LDL: _____ HDL: _____ Triglyceride: _____	Date: _____ Systolic: _____ Diastolic: _____	Yes: _____ No: _____ Unknown: _____	Date: _____ Yes: _____ No: _____	Yes: _____ No: _____ No: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____	Yes: _____ No: _____
		Yes: _____ No: _____		Yes: _____ No: _____	Date: _____ Total Cholesterol: _____ LDL: _____ HDL: _____ Triglyceride: _____	Date: _____ Systolic: _____ Diastolic: _____	Yes: _____ No: _____ Unknown: _____	Date: _____ Yes: _____ No: _____	Yes: _____ No: _____ No: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____	Yes: _____ No: _____
		Yes: _____ No: _____		Yes: _____ No: _____	Date: _____ Total Cholesterol: _____ LDL: _____ HDL: _____ Triglyceride: _____	Date: _____ Systolic: _____ Diastolic: _____	Yes: _____ No: _____ Unknown: _____	Date: _____ Yes: _____ No: _____	Yes: _____ No: _____ No: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____ N/A: _____	Yes: _____ No: _____	Yes: _____ No: _____

This form is based on the American Academy of Family Physicians Diabetes METRIC.

Student signature: _____ Date: _____

Reviewed by (faculty signature) _____ Date: _____