DIABETES S.E.T. for SUCCESS
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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: _____

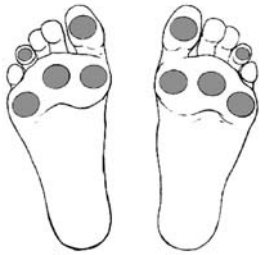
Extremities: _____

Neuro: _____

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

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

Foot Exam Test Areas



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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