

## DIABETES FLOW SHEET

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Male/Female \_\_\_\_\_

History: \_\_\_\_\_

**NOTE: Document contraindications to any measure(s)**

Vaccines: Pneumonia \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Flu: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

		Date/Result			
<b>Each Visit</b>	Weight				
	Blood Pressure				
	Glucose				
3-4 Mos	A1C				
<b>Yearly</b>	Foot Exam (visual, sensory/monofilament, pulses,)				
	Dilated Eye Exam				
	Fasting Lipids				
	Triglycerides				
	Micro Albumin				
	BUN/Creatinine				
<b>Prevention/Education</b>	Diabetes Educator Referral				
	Exercise				
	Diet/Cholesterol				
	Foot Care				
	Smoking cessation				
	Mammogram (if Female)				
	Colorectal cancer screening				