J.A. Hildes Northern Medical Unit

DIABETIC ANNUAL REVIEW

Patient Name: _____ Allergies: _____ Date: ____ / ____ / _____

Year of Diagnosis: _____ yy / mm / dd

Concerns: _____

Eating Habits: adequate ❑ inadequate ❑ Smoking: Yes ❑ No ❑ Quit date _____

Exercise active ❑ inactive ❑ Alcohol: Yes ❑ No ❑

Medications: _____ Concomitant Illness: _____

Physical Examination:

Weight: _____ Height: _____ BMI: _____ BP: _____ Glucose: _____ Urine Dip Protein: _____

Fundi: _____ Head & Neck _____ Carotids: _____

Lungs: _____ CVS: _____

Abdomen: _____ Skin: _____

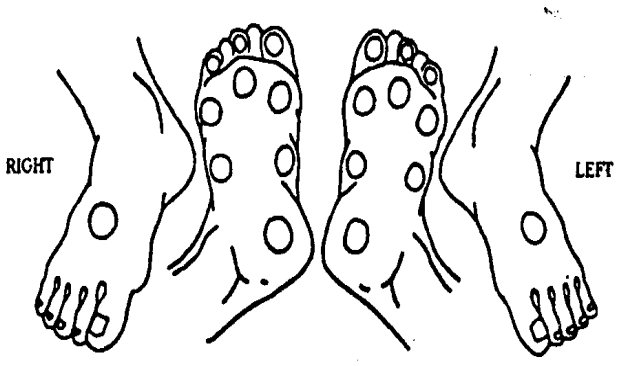
Foot Exam: Color: _____ Nail condition: _____ Ulcers ❑

Peripheral Pulses: **DP** +1 +2 +3 +4 **PT** +1 +2 +3 +4

Footwear type: Extra-depth ❑ Special ❑ Inadequate ❑ Other _____

10g Monofilament sensation screen:

Label: Sensory Level with a "+" in the circled areas of the foot if the patient can feel the 10 gram (5.07 Semmes-Weinstein) monofilament and "-" if patient cannot feel the monofilament



DRAW ULCERS ON DIAGRAM

Refer to Diabetic foot clinician ❑ HSC ❑

EKG: (Initial visit then yearly) Date: _____ Result: _____ ? Stress Test ❑

Assessment with retinal screening program ❑ Ophthalmology ❑

Signature of Clinician

Record all lab on Diabetic Flow sheet

J.A. Hildes
Northern
Medical Un t

DIABETIC ANNUAL REVIEW