Diabetes Visit Assessment Tool*

Patient name:	Date of birth:
Phone number:	Gender:

Care	Frequency	Visit date / /	Visit date / /	Visit date / /	Visit date / /
Complete history & physical exam	Initial visit and annually	☐	☐	☐	☐
Blood pressure Goal: <140/90	Every visit	**BP: /**	**BP: /**	**BP: /**	**BP: /**
Weight & BMI BMI goal: 18.5 -24.9	Every visit **Height: _____**	**Weight: _____ BMI: _____**	**Weight: _____ BMI: _____**	**Weight: _____ BMI: _____**	**Weight: _____ BMI: _____**
A1c Goal: <7	2-4 times a year	☐	☐	☐	☐
Fasting lipid panel LDL: <100 HDL: >40 M; >50 F Triglycerides: <150	Periodically	☐ **LDL** ☐ **HDL** ☐ **Triglycerides**	☐ **LDL** ☐ **HDL** ☐ **Triglycerides**	☐ **LDL** ☐ **HDL** ☐ **Triglycerides**	☐ **LDL** ☐ **HDL** ☐ **Triglycerides**
Urine protein test	Annually	☐	☐	☐	☐
Serum creatinine	Annually	☐	☐	☐	☐
Flu vaccine	Every flu season	☐	☐	☐	☐
Pneumonia vaccine	1-2 doses	☐	☐	☐	☐
Hepatitis B vaccine	3 doses	☐	☐	☐	☐
Comprehensive foot exam	Annually Visual inspection every visit	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Depression/mood disorder screening	Annually/ongoing	☐	☐	☐	☐
Diet & physical activity counseling	Ongoing/refer as needed	☐	☐	☐	☐
Diabetes education (DSME)	Ongoing/refer as needed	☐	☐	☐	☐
Self blood glucose monitoring record assessment	Ongoing	☐	☐	☐	☐
Medication review Insulin Orals ACE/ARB Statins ASA Other	Review every visit	☐ **Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____**	☐ **Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____**	☐ **Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____**	☐ **Insulin _____ Orals _____ ACE/ARB _____ Statins _____ ASA _____ Other _____**
Comments (Plan adherence, follow-up, referrals etc.)	Ongoing				
Signature					

*Recommendations based on the American Diabetes Association Standards of Medical Care - 2018