

APPENDIX 3. DM/HTN Flow Sheet

DM / HTN Flow Sheet

(place if item completed or positive, comment if abnormal)

SUBJECTIVE:	Date:
Symptoms since last visit:	<input type="checkbox"/> Dizziness <input type="checkbox"/> Weakness <input type="checkbox"/> Numbness or Paresthesias <input type="checkbox"/> TIA Symptoms <input type="checkbox"/> Chest Pain or Tightness <input type="checkbox"/> Exertional Dyspnea <input type="checkbox"/> Palpitations <input type="checkbox"/> Vision Change <input type="checkbox"/> Hypoglycemic episodes _____ <input type="checkbox"/> "Sick" days <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Other:
OBJECTIVE:	FBS: _____ mg/dl (today) Latest HbA1C _____% (date _____)
Vital Signs	T: _____ P: _____ R: _____ BP: _____ / _____
HEENT: (esp. Retinal)	Fundi:
Lungs / Heart	
Abdomen	
Feet / Vascular / Neuropathy	Foot exam + Pedal Pulses: Distal Sensory Exam + Monofilament test:
Mental Health	Depression Screen:
Other:	
ASSESSMENT: <i>Note: If BP or DM not under optimal control, intensify regimen today!!!</i>	1. 2. 3.
PLAN: *Patient Education:	<input type="checkbox"/> Exercise prescription: <input type="checkbox"/> Weight Reduction (specify goal or target weight): <input type="checkbox"/> Specific Diet <input type="checkbox"/> low sat fat <input type="checkbox"/> _____ cal ADA diet <input type="checkbox"/> Other: <input type="checkbox"/> Glucometer self-monitoring _____ x/ day <input type="checkbox"/> Self-adjust insulin dosing <input type="checkbox"/> Foot Care <input type="checkbox"/> Eye Care <input type="checkbox"/> Cardiovascular Risk <input type="checkbox"/> Other:
*Current Meds & dose	(put <input checked="" type="checkbox"/> mark if dose & schedule unchanged, otherwise list new regimen)
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
* Referrals	<input type="checkbox"/> Optometry <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Podiatry <input type="checkbox"/> Diabetes Clinic <input type="checkbox"/> Nutritionist <input type="checkbox"/> Cardiology <input type="checkbox"/> Renal <input type="checkbox"/> Health Educator <input type="checkbox"/> Physical Therapy (Exercise Rx)
* Labs	<input type="checkbox"/> Fasting Glucose <input type="checkbox"/> Hgb A1c <input type="checkbox"/> BUN/Creat <input type="checkbox"/> SMA-7 <input type="checkbox"/> Creatinine Clearance <input type="checkbox"/> Urine microalbumin (spot) <input type="checkbox"/> microalbumin / creatinine ratio <input type="checkbox"/> 24 hr urine protein <input type="checkbox"/> Lipid Profile <input type="checkbox"/> AST / ALT <input type="checkbox"/> Other:
* Preventive Services -- Vaccines	<input type="checkbox"/> Influenza <input type="checkbox"/> Pneumovax <input type="checkbox"/> dT
-- Cancer Screening	<input type="checkbox"/> Pap <input type="checkbox"/> Mammogram <input type="checkbox"/> FOBT <input type="checkbox"/> Sigmoid/Colonoscopy <input type="checkbox"/> PSA
*Other Action Items:	1. 2.
>Follow-up:	Return to Clinic: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 6 <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months Signature: _____

Patient Name: _____ Med. Rec. #: _____
 Date of Birth: _____ Male _____ or Female _____