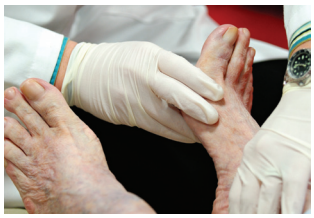
I Can Control My Diabetes By Working With My Health Care Team!

To team up with my pharmacist, I will—

- Make a list of all my medicines, the exact doses, and include over–the-counter medicines, vitamins, and herbal supplements.
- Update and review the list with my pharmacist every time there is a change.
- Ask how to take my medicine and use supplies to get the best results at the lowest cost.
- Ask about new medicines that I can talk about with my doctor.



To team up with my podiatrist, I will—

- Get a full foot exam by a podiatrist at least once each year.
- Learn how to check my feet myself every day.
- See my podiatrist right away if I develop any foot pain, redness, or sores.
- Ask about the right shoes for me.
- Make sure my feet are checked at every health care visit.

To team up with my eye care provider, I will—

- Ask for a full eye exam with dilated pupils each year.
- Ask how to prevent diabetic eye disease.
- Ask what to do if I have vision changes.

To team up with my dental provider, I will—

- Visit my dental provider at least once a year for a full mouth exam.
- Learn the best way to brush my teeth and use dental floss.
- Ask about the early signs of tooth, mouth, and gum problems.
- Ask about the link between diabetes and gum disease.

To control my diabetes every day, I will—

- Be more active—walk, play, dance, swim, and turn off the TV.
- Eat a healthy diet—choose smaller portions, more vegetables, and less salt, fat, and sugar.
- Quit if I smoke or use other tobacco products—tobacco use increases the risk of health problems from diabetes. To quit, call: 1-800-QUIT-NOW (1-800-784-8669).
- Ask all my providers to share my exam results with my other health care providers.
- Learn about managing my diabetes by visiting www.cdc.gov/diabetes/ndep
- Control my ABCs of diabetes:
  - **A1C**. This test measures average blood sugar levels over the last 3 months. The goal is less than 7% for many people but your health care provider might set different goals for you.
  - **Blood Pressure.** High blood pressure causes heart disease. The goal is less than 140/90mm Hg for most people.
  - **Cholesterol**. Bad cholesterol or LDL (Low Density Lipoprotein) builds up and clogs your arteries.

To get more FREE information on how to prevent or control diabetes, call the Centers of Control and Disease Prevention (CDC) at 1-800-CDC-INFO (800-232-4636), TTY line 1-(888) 232-6348 or visit www.cdc.gov/diabetes/ndep.

National Diabetes Education Program NDEP
A program of the National Institutes of Health and the Centers for Disease Control and Prevention
CS241400-B NDEP-128

Diabetes Head to Toe Checklist Examination Report

Your organization's name here_____

From: | **To:**

Patient Information:

Name: _____ **DOB:** _____

Diabetes: ❑ Type 1 ❑ Type 2 ❑ Gestational ❑ Prediabetes **HbA1c Goal:** _____ ❑ < 6 months ❑ >/= 6 months ❑ Unknown

Duration of Diabetes (in years): _____ **Current Diabetes Therapy:** ❑ Insulin ❑ Oral Hypoglycemic ❑ Diet Control ❑ None

Results of Last Finger-stick blood glucose reading (per patient): _____ ❑ N/A Patient reports under control ❑ Yes ❑ No

Dietary Counseling ❑ Yes ❑ No Type of Diet: _____

MEDICINES

Date: _____

Patient has a written med list ❑ Yes ❑ No

OTC Meds Used: (if none: ❑)

Herbal Meds Used: (if none: ❑)

Pharmacist reviewed meds on (date): _____

Patient has Rx for: (provide reason if "no")

Aspirin ❑ Yes ❑ No:

Cholesterol med ❑ Yes ❑ No:

ACE inh or ARB ❑ Yes ❑ No:

Reports Side Effects to Meds ❑ Yes ❑ No

If yes, describe:

Reports hypoglycemia events? ❑ Yes ❑ No

If yes, describe:

Does patient know their current:

A1c? ❑ Yes ❑ No Goal A1c?: ❑ Yes ❑ No

LDL? ❑ Yes ❑ No Goal LDL? ❑ Yes ❑ No BP? ❑ Yes ❑ No Goal BP? ❑ Yes ❑ No

Home Glucose Monitoring Frequency:

❑ once daily

❑ twice daily

❑ 3-4 times daily

❑ Other: _____

If on insulin, list current dose:

List dosing times:

KIDNEY/HEART & VASCULAR

Date: _____

Risk factors in addition to diabetes: (give dates for all)

Blood Pressure: Goal:_____ Measured: _____

Total, LDL and HDL cholesterol, triglycerides: (LDL goal and measured values for all)

_____

_____

Smoking status: (circle all that apply)

Never Former Current Willing To Quit

Assessments: (give dates for all)

Urine albumin-to-creatinine ratio: _____

Serum creatinine and estimated GFR:_____

_____

Potassium: _____

Hemoglobin: _____

History of myocardial infarction, heart failure, or stroke:_____

Heart or brain testing (e.g. stress test, echo, angiogram, CT scan, ultrasound, MRI): _____

History of dialysis or kidney transplant:

_____

Kidney tests (ultrasound, CT Scan, Angiogram):_____

FEET

Date: _____

Current ulcer or history of a foot ulcer? ❑ Yes ❑ No

Foot Exam: Skin, Hair, and Nail Condition

Is the skin thin, fragile, shiny and hairless? ❑ Yes ❑ No

Are the nails thick, too long, ingrown, or infected with fungal disease? ❑ Yes ❑ No

Note Musculoskeletal Deformities

❑ Toe deformities ❑ Bunions (Hallus Valgus) ❑ Charcot foot

❑ Foot drop ❑ Prominent Metatarsal Heads

Pedal Pulses - "P" for present or "A" for absent

Posterior tibial Left__ Right__ Dorsalis pedis Left__Right__

Risk Categorization check appropriate box.

❑ **Low Risk Patient**	❑ **High Risk Patient**
All of the following:	One or more of the following:
❑ Intact protective sensation	❑ Loss of protective sensation
❑ Pedal pulses present	❑ Absent pedal pulses
❑ No deformity	❑ Foot deformity
❑ No prior foot ulcer	❑ History of foot ulcer
❑ No amputation	❑ Prior amputation

EYES

Date: _____

Visual Acuity (best corrected) Right:_____ Left:_____

Intraocular Pressure Right:_____ Left:_____

❑ **Dilated Fundus Exam Performed**

Diagnosis:

No Diabetic Retinopathy ❑ Yes ❑ No

Non-Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Plan:

❑ Monitor Only ❑ Repeat Dilated Exam In _____ months

❑ Additional Testing/Treatment Recommended:

Proliferative Diabetic Retinopathy ❑ Yes ❑ No

Clinically Significant Macular Edema ❑ Yes ❑ No

MOUTH

Date: _____

Examination Findings

Intraoral/Extraoral:

Caries:

Periodontal (health, abscesses, gingivitis, periodontitis):

Xerostomia:

Fungal infection:

Parotid gland changes:

Functional (eating, swallowing, etc) concerns: _____

Additional Testing/Treatment Recommended: _____

Refer to Specialist: _____ Re-evaluate in _____months(s)

Management:

❑ Follow-up:_____ months ❑ Patient education/discussion ❑ Information pamphlet given

Referral To:_____ For:_____

Other_____ Doctor's Signature_____