



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 for 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.



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 <input type="checkbox"/> Yes <input type="checkbox"/> No OTC Meds Used: (if none: <input type="checkbox"/>) Herbal Meds Used: (if none: <input type="checkbox"/>) Pharmacist reviewed meds on (date): _____ Patient has Rx for: (provide reason if "no") Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No: Cholesterol med <input type="checkbox"/> Yes <input type="checkbox"/> No: ACE inh or ARB <input type="checkbox"/> Yes <input type="checkbox"/> No:	Reports Side Effects to Meds <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: Reports hypoglycemia events? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: Does patient know their current: A1c? <input type="checkbox"/> Yes <input type="checkbox"/> No Goal A1c?: <input type="checkbox"/> Yes <input type="checkbox"/> No LDL? <input type="checkbox"/> Yes <input type="checkbox"/> No Goal LDL? <input type="checkbox"/> Yes <input type="checkbox"/> No BP? <input type="checkbox"/> Yes <input type="checkbox"/> No Goal BP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Glucose Monitoring Frequency: <input type="checkbox"/> once daily <input type="checkbox"/> twice daily <input type="checkbox"/> 3-4 times daily <input type="checkbox"/> 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: _____ _____	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: _____
		Potassium: _____ Hemoglobin: _____	Kidney tests (ultrasound, CT Scan, Angiogram): _____

FEET	Date: _____ Current ulcer or history of a foot ulcer? <input type="checkbox"/> Yes <input type="checkbox"/> No Foot Exam: Skin, Hair, and Nail Condition Is the skin thin, fragile, shiny and hairless? <input type="checkbox"/> Yes <input type="checkbox"/> No Are the nails thick, too long, ingrown, or infected with fungal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Note Musculoskeletal Deformities <input type="checkbox"/> Toe deformities <input type="checkbox"/> Bunions (Hallus Valgus) <input type="checkbox"/> Charcot foot <input type="checkbox"/> Foot drop <input type="checkbox"/> 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. <input type="checkbox"/> Low Risk Patient <input type="checkbox"/> High Risk Patient All of the following: One or more of the following: <input type="checkbox"/> Intact protective sensation <input type="checkbox"/> Loss of protective sensation <input type="checkbox"/> Pedal pulses present <input type="checkbox"/> Absent pedal pulses <input type="checkbox"/> No deformity <input type="checkbox"/> Foot deformity <input type="checkbox"/> No prior foot ulcer <input type="checkbox"/> History of foot ulcer <input type="checkbox"/> No amputation <input type="checkbox"/> Prior amputation
-------------	---	--

EYES	Date: _____ Visual Acuity (best corrected) Right: _____ Left: _____ Intraocular Pressure Right: _____ Left: _____ <input type="checkbox"/> Dilated Fundus Exam Performed Diagnosis: No Diabetic Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No Non-Proliferative Diabetic Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No	Plan: <input type="checkbox"/> Monitor Only <input type="checkbox"/> Repeat Dilated Exam In _____ months <input type="checkbox"/> Additional Testing/Treatment Recommended: Proliferative Diabetic Retinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No Clinically Significant Macular Edema <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------	---	---

MOUTH	Date: _____ Intraoral/Extraoral: Caries: Periodontal (health, abscesses, gingivitis, periodontitis): Functional (eating, swallowing, etc) concerns: _____ Additional Testing/Treatment Recommended: _____ Refer to Specialist: _____	Examination Findings Xerostomia: Fungal infection: Parotid gland changes: Re-evaluate in _____ months(s)
--------------	---	---

Management: <input type="checkbox"/> Follow-up: _____ months <input type="checkbox"/> Patient education/discussion <input type="checkbox"/> Information pamphlet given Referral To: _____ For: _____ Other _____ Doctor's Signature _____
