Diabetes Clinical Form

		QUARTERLY ASSESSMENTS			
***Dates of Assessments		Date	Date	Date	Date
***Height (only once)					
***Weight					
***Blood Pressure					
Smoking Status: (Y/N)					
Health Insurance: (Y/N)					
LAB: HgbA1c					
LAB: Lipids **Please check:** ☐ Fasting ☐ Non-Fasting	Total Cholesterol				
	HDL				
	LDL				
	Triglycerides				
LAB: Microalbumin					
EXAMS:	Foot Check/ Annual Foot Exam				
	Eye Exam				
	Dental Exam				
	EKG (Y/N)				
IMMUNIZE:	dT				
	Pneumo				
	Flu				

This product was developed by the Full Circle Diabetes Program of the Minneapolis American Indian Center and Native American Community Clinic in Minneapolis, MN with support from the Robert Wood Johnson Foundation® in Princeton, NJ.

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	ASSESSMENTS
Date became a patient of clinic	
Date diagnosed with diabetes	
Comorbid Conditions (Please check type(s) / date of diagnoses)	☐ Cardiovascular Disease Date:
	☐ High blood pressure Date:
	☐ High cholesterol Date:
	☐ Peripheral vascular disease Date:
	☐ Peripheral neuropathy Date:
	☐ Autonomic neuropathy Date:
	☐ Retinopathy Date:
	☐ Kidney disease Date:
	☐ Asthma/COPD Date:
	☐ Arthritis Date:
	☐ Other Date:
	☐ Other Date:
	☐ Other Date:
	☐ Other Date:
	☐ Other Date:
Pregnancy or Gestational Diabetes (If yes, record indicator / date) (Y/N)	Date:
Complications: Foot Amputations (Y/N) (If yes, please indicate)	Date: Date:

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