Diabetes Self-Management Training (DSMT) - One-Year Follow-up

Name (Last) (First) (M.I.)	Physician's Name: __FP/GP__Ped__Int __Endo __Other	Phone	Address
_____		_____	_____ _____

___ 1:1 ___ Phone —– Letter *OR* —– Dropped-out —– Refused —– Unable to Contact —– Moved —– Deceased

Clinical Data Since Last Encounter (If Applicable)

Weight (lbs) _____

Blood Pressure_____/_____

A1c_____ Date_____

Range_____ - _____

Lipid Profile Date_____

Total Cholesterol _____

HDL-C _____LDL-C _____

Annual Microalbumin Screen

____ Proteinuria Present
____ Proteinuria Absent/Screen done
Screen result _____
Date_____
Screen test used:
_____ Albumin-to-Creatinine Ratio (Spot)
_____ 24-hour Collection
_____ Timed Collection (eg 4 hr or overnight)

Type/Management of Diabees

List medications/medical nutrition therapy as appropriate.

- ☐ Type 1_____
- ☐ Type 2 – Diet and Exercise Only
- ☐ Type 2 – Oral Agent(s):
  - ☐ Monotherapy_____
  - ☐ Combination Therapy _____
- ☐ Type 2 – Insulin _____
- ☐ Type 2 – Insulin & Oral(s)
- ☐ Other Type: _____

Specify Management _____

Health Care Visits in Past Year

Record number of visits with a provider as appropriate.

____Dilated Eye Examination
Date of last exam _____
_____Dentist
_____Podiatrist
_____OB/GYN
_____ Mental Health Professional
_____Urologist
_____Doctor Visit
_____Emergency Room Visit
___ Hospital Admissions
☐ Any Cause
☐ DM-Related

Health Status Assessment: Medical Conditions and Treatment

Check only if applicable. List medication(s)/description as appropriate.

____ Allergies _____
____ Herbal Supplements _____
____ Tobacco Use _____
____ Alcohol Use _____
____ Other substance/product use _____
____ Surgery (Any) _____
____ Eye Disease _____
____ Heart Disease _____
____ Hypertension _____
____ Hyperlipidemia _____
____ Peripheral Vascular Disease _____
____ Respiratory Disease _____
____ Gastrointestinal Disease _____
____ Pancreatitis/Pancreatic Surgery _____
____ Renal Disease _____
____ Genitourinary Disease _____
____ Sexual Dysfunction _____
____ Foot Complication _____
____ Current Deformity/Ulcer _____
____ Amputation, Lower Extremity (Specify) _____
____ Monofilament Test Done _____
____ Loss of Protective Sensation _____
____ Neuropathy _____
____ Other Neurological Disease _____
____ Arthritis/Musculoskeletal Disease _____
____ Other Endocrine disease _____
____ Cancer _____
____ Mental Health/Psychosocial _____
____ Recurring Infection _____
____ Hx DKA/HHNS _____
____ Recurring Hypoglycemia _____
____ Planning/Current Pregnant _____
____ Other _____

_____/_____
Signature of Instructor **Date**