



# COMPREHENSIVE DIABETIC CARE HRE ENDOCRINOLOGIST FORM

PATIENT'S NAME \_\_\_\_\_  
 DATE \_\_\_\_\_  
 IDENTIFICATION NUMBER \_\_\_\_\_  
 SEX: FEMALE  MALE

SPECIALIST'S NAME \_\_\_\_\_  
 NATIONAL PROVIDER IDENTIFIER \_\_\_\_\_  
 DIAGNOSIS (ES) \_\_\_\_\_  
 ICD-9 \_\_\_\_\_

YEARS AS DIABETIC \_\_\_\_\_ SMOKER YES  NO

**RISK FACTORS**

HTN	YES <input type="checkbox"/>	NO <input type="checkbox"/>	STROKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
OBESITY	YES <input type="checkbox"/>	NO <input type="checkbox"/>	HISTORY OF MI	YES <input type="checkbox"/>	NO <input type="checkbox"/>
HYPERCHOLESTEROLEMIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DEMENTIA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ATHEROSCLEROSIS	YES <input type="checkbox"/>	NO <input type="checkbox"/>	DEPRESSION	YES <input type="checkbox"/>	NO <input type="checkbox"/>
THYROID DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>	OTHER MENTAL CONDITIONS	_____	

DATE OF LAST NUTRITIONAL EVALUATION \_\_\_\_\_ DATE OF LAST EVALUATION TREATMENT \_\_\_\_\_

**GENERAL PREVENTIVE SERVICES (IF INFORMATION AVAILABLE)**

FEMALE			MALE		
	DATE	RESULT		DATE	RESULT
MAMMOGRAM			PROSTATE CANCER SCREENING		
PAP SMEAR			PSA		
BONE MASS MEASUREMENT			DIGITAL RECTAL EXAM		
COLON CANCER SCREENING			BONE MASS MEASUREMENT		
SIGMOIDOSCOPY			COLON CANCER SCREENING		
COLONOSCOPY			SIGMOIDOSCOPY		
BARIUM ENEMA			COLONOSCOPY		
FECAL OCCULT BLOOD			BARIUM ENEMA		
GLAUCOMA SCREENING			FECAL OCCULT BLOOD		
			GLAUCOMA SCREENING		

DIABETES SPECIFIC SCREENING TEST	DATE	RESULTS	CONTROLLED	NON CONTROLLED	ASSESSMENT AND RECOMMENDATIONS
HGA1C					
LDL					
RETINAL EYE EXAM					
SCREENING FOR NEPHROPATHY					
NEPHROLOGIST EVALUATION IF APPLICABLE					
U/A FOR MICROALB					
24 HOUR URINE COLLECTION					
ARB OR ACE INHIBITOR TREATMENT					
BLOOD PRESSURE					

NEXT VISIT 1 MONTH  3 MONTH  6 MONTH  OTHER \_\_\_\_\_  
 PATIENT UNDER CONTROL YES  NO

**RECOMMENDATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**MEDICATIONS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_