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.
# Diabetes Head to Toe Checklist Examination Report

**Your organization’s name here**

## Patient Information:

### Name: ____________________________ DOB: ____________________________

### Diabetes:
- Type 1
- Type 2
- Gestational
- Prediabetes

### HbA1c Goal: ________

#### 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: ____________________________

### Other: ____________________________________________

### Doctor’s Signature: ____________________________

### Referral To: ____________________________ For: ____________________________

### Re-evaluate in ________ months(s)

### Information pamphlet given: Yes  No

### Pharmacist reviewed meds on (date): ______

### Herbal Meds Used: (if none: ______)

### Patient has a written med list: Yes  No

### OTC Meds Used: (if none: ______)

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

### Aspirin: Yes  No

### Cholesterol med: Yes  No

### ACE inh or ARB: Yes  No

### ACE inh or ARB: Yes  No

### Diabetes Head to Toe Checklist Examination Report

### MEDICINES (MOUTH)

#### 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

### 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)

- History of myocardial infarction, heart failure, or stroke: ______

- History of kidney disease:

### 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
  - All of the following:
    - Intact protective sensation
    - Loss of protective sensation
    - Absent pedal pulses
    - Foot deformity
    - History of foot ulcer
    - No amputation

- High Risk Patient
  - One or more of the following:
    - No amputation

### Plan:

- Monitor Only
- Repeat Dilated Exam In ________ months

### Additional Testing/Treatment Recommended:

### 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

### Examination Findings:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Diabetic Retinopathy</td>
<td>Monitor Only</td>
</tr>
<tr>
<td>Non-Proliferative Diabetic Retinopathy: Yes</td>
<td>Repeat Dilated Exam In ________ months</td>
</tr>
<tr>
<td>No amputation</td>
<td>Additional Testing/Treatment Recommended:</td>
</tr>
<tr>
<td>Clinical Significant Macular Edema: Yes</td>
<td>Proliferative Diabetic Retinopathy: Yes</td>
</tr>
<tr>
<td>History of foot ulcer</td>
<td>No</td>
</tr>
<tr>
<td>No AMputation</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetic Retinopathy</td>
<td>No</td>
</tr>
<tr>
<td>No amputation</td>
<td>No</td>
</tr>
</tbody>
</table>

### MOUTH

#### Date: ____________________________

- Intraoral/Extraoral: ____________

- Caries: ____________

- Periodontal (health, abscesses, gingivitis, periodontitis):

- 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: ____________________________