MI PEDS
Michigan Pediatric Endocrine & Diabetes Services

Diabetes Follow-Up Form

NAME: _____
Date of appointment: _____/_____/_____ (mm/dd/yyyy) BIRTHDATE: _____

General Information:

Who came to the visit today with the patient? ☐ Mother ☐ Father ☐ Other: _____
What questions do you have today? _____
Any educational topics you would like to cover today? Please Circle: Hyperglycemia Hypoglycemia Sick Day Exercise Medication Food Label Reading Stress Sexual Activity Drugs Alcohol Other: _____

Diabetes Care and Monitoring:

Insulin: How do you/your child administer insulin? ☐ Injections ☐ Insulin Pump Note: your provider will confirm doses.
Do you/your child take insulin before the meal? ☐ No ☐ Yes If yes, how many minutes before? _____
How often do you/your child check his/her blood glucose (BG) per day? ☐ Rarely ☐ 1-4 ☐ 5-7 ☐ 8-9 ☐ >9
Does you/your child use CGM? ☐ No ☐ Yes Brand name _____ ☐ Continuously or ☐ Occasionally
What type of meter do you/your child use? _____
What sites do you/your child use for injections or pump sites? ☐ Abdomen ☐ Buttocks ☐ Arm ☐ Leg

Acute Diabetes Events and Hypoglycemia:

Have you/your child had moderate or large ketones since last visit? ☐ No ☐ Yes
Hospital admission or Emergency Department visit since last visit? ☐ No ☐ Yes
Any severe lows (BG < 50) since last visit? ☐ No ☐ Yes Nighttime lows? ☐ No ☐ Yes
How often do low sugars occur per week? ☐ Rarely ☐ 1-3 ☐ 4-6 ☐ 7-9 ☐ >9
Do you/your child have symptoms with low blood sugars? ☐ No ☐ Yes If yes, describe: _____
Below what BG number do symptoms occur? _____ How do you/your child treat low sugars? _____
Have the symptoms changed over time? ☐ No ☐ Yes _____

Self-Management/Behaviors and Exercise:

Do you review the BG or CGM data? ☐ No ☐ Yes Do you feel comfortable adjusting doses? ☐ No ☐ Yes
Do you adjust the dose based on CGM arrows? ☐ No ☐ Yes By how much? _____
How often do you/your child exercise? ____ days per week Type of exercise: _____ How do you manage blood sugar with exercise? ☐ Pre-exercise BG ☐ Snacks ☐ Temp basal rate ☐ Uncovered carbohydrate

Sick Day Management:

Do you know when to check for ketones? ☐ No ☐ Yes
Do you know when to call your provider? ☐ No ☐ Yes

Social History and Concerns:

Who lives at home with your child? _____
Have there been changes in home life or family health since last visit? ☐ No ☐ Yes _____
Does your child attend school/day care? ☐ No ☐ Yes Grade: _____
Have you/your child missed school days due to diabetes? ☐ No ☐ Yes Number of days this year _____
Do you/your child drive a car? ☐ No ☐ Yes Precautions taken: ☐ Check BG before driving ☐ Keep carbs in the car
Do you/your child (circle any positives) use (that you know): drugs tobacco alcohol

Diet:

Do you count carbohydrates? ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never Do you weigh foods? ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never Do you read food labels? ☐ Always ☐ Mostly ☐ Sometimes ☐ Rarely ☐ Never Are you/is your child on a gluten-free diet? ☐ No ☐ Yes Special diet? ☐ No ☐ Yes _____

Review of Systems (since last visit): check all that are present:

☐ Abdominal Pain ☐ Anxiety ☐ Depression ☐ Difficulty Feeling Hypoglycemia ☐ Skin Concerns ☐ Fatigue ☐ Foot Concerns ☐ Headaches ☐ Severe Hypoglycemia ☐ Excessive thirst ☐ Excessive Urination ☐ Nighttime concerns ☐ Infections ☐ Site Issues ☐ Abnormal Periods (females) ☐ Sleep concerns ☐ Stress ☐ Other: _____

Other History:

When was your/ your child's last eye exam? _____ Flu shot? _____
Person filling out form _____Relationship to patient: _____