**Icon

Description automatically generated with medium confidenceDiabetes 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_