



# My Diabetes Plan

Patient Name: \_\_\_\_\_


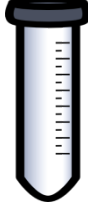

Date: \_\_\_\_\_




Medical Clinic Phone #: \_\_\_\_\_

## - WEIGHT -

Healthy BMI: <25	Overweight: 25-30	Obese: > 30	Morbidly Obese: > 40
Weight: _____	BMI: _____	Goal Weight: _____	Lose _____ lbs per month

## - LABS AND EXAMS -

Long Term Blood Sugar (A1C)	Cholesterol	Blood Pressure
Last A1C: _____ Current A1C: _____ 	Your risk%: _____ Or LDL _____ 	Your BP: _____ 
<b>How Often Is It Needed?</b>	<b>Goal? If &gt;40yo on a statin</b>	<b>Goal? Less than 140/90</b>
Every 3-6 months	<input type="checkbox"/> Statin not indicated	
<b>Goal? Less than 7.0 or _____</b>		
<b>Blood Sugar Medications:</b>	<b>Cholesterol Medications:</b>	<b>Blood Pressure Medicine:</b>

Foot Exam	Eye Exam	Kidney Health
Date: _____ Pulse: _____ Skin: _____ Sensation: _____ 	Date: _____ Results: _____ Next Exam: _____ 	Date: _____ GFR: _____ Microalbumin ratio: _____ 
<b>How Often Is It Needed?</b>	<b>How Often Is It Needed?</b>	<b>How Often Is It Needed?</b>
At least once per year	Every 2 years (if normal)	At least once per year
<b>Goal? No sores, good sensation</b>	<b>Goal? No changes in vision</b>	<b>Goal? GFR&gt;60 and Microalbumin less than 30</b>

Immunizations	Tobacco Use	Heart Protection
 <ul style="list-style-type: none"> <li><input type="checkbox"/> Flu</li> <li><input type="checkbox"/> Pneumonia</li> <li><input type="checkbox"/> Hepatitis B</li> </ul>	 ASH LINE 1-800-55-66-222	 <ul style="list-style-type: none"> <li><input type="checkbox"/> Aspirin 81mg daily *if risk is &gt;10%</li> <li><input type="checkbox"/> Not indicated</li> </ul>

## - WEIGHT LOSS & PHYSIAL ACTIVITY GOALS-

Recommend Increasing Physical Activity \_\_\_\_\_ Times Per Week for \_\_\_\_\_ Minutes.

Eat Healthier:  High Fiber, Low Carb

Other Notes and Plan:

## - CHECKING YOUR BLOOD SUGAR -

Sugar Goal Before Breakfast: 80-130		Sugar Goal 2 Hours After Eating: Less than 180	
When Should I Test My Sugar?		What Days Should I Test My Sugar?	
<input type="checkbox"/> Before Breakfast	<input type="checkbox"/> 2 Hours After Breakfast	<input type="checkbox"/> Everyday	<input type="checkbox"/> 3 times a week
<input type="checkbox"/> Before Dinner	<input type="checkbox"/> 2 Hours After Lunch	<input type="checkbox"/> Only when I feel sick	
<input type="checkbox"/> Before Bed	<input type="checkbox"/> 2 Hours After Dinner	<input type="checkbox"/> Other: _____	

## -BLOOD SUGAR LOG-

- 1. RECORD THE DATE, SUGAR VALUE AT THE APPROPRIATE TIME, AND INSULIN DOSE TAKEN**  
**2. BRING YOUR LOG TO YOUR NEXT VISIT 3. CALL THE CLINIC IF YOUR SUGAR IS REGULARLY LESS THAN 80!**

Date	Breakfast		Lunch		Dinner		Bedtime
	Before	After	Before	After	Before	After	
Comments:							
Comments:							
Comments:							
Comments:							
Comments:							