Family Medicine Clerkship Chart Review

You are to review the charts of 3 patients you have seen who have been diagnosed with diabetes mellitus and fill in all appropriate information on these patients that applies for the past 12 months.
(see example listed)

Student Name:

Clerkship Site:

Age	Gender	DM diagnosis in PMH? (Yes or No)	A1C value (Date)	ACEi or ARB? (Yes or No)	Lipids value (Date)	Blood Pressure (Date)	Dialated Retinal Exam	Microalbumin (Date)	Flu Vaccine in the last 12 months?	Complete Foot Exam	Does the chart recommend Aspirin Therapy (dose ≥ 75 mg)	Is the Patient a smoker?	Has the patient been counseled to stop smoking?
60	*M*	*Yes:* X *No:*_____	*8.3 (9/4/2012)*	*Yes:* X *No:*_____	Date: *4/4/12* Total Cholesterol: 245 *LDL :* 170 *HDL:* 75 *Triglyceride:* 65	Date: 4/4/12 *Systolic:* 171 *Diastolic:* 78	*Yes:*__________ *No:*__________ *Unknown:* X	Date:_______ *Yes:*________ *No:* X	Yes: X *No:*_________	Yes: X *No:*________ *N/A:*________	*Yes:*_______ *No:* X *N/A:*________	Yes: X *No:*_________	Yes: X *No:*_________
		Yes:____ *No:*_____		Yes:____ *No:*_____	Date: __________________ Total Cholesterol: ________ *LDL:* __________________ *HDL:* __________________ *Triglyceride:* __________	Date:________ *Systolic:*______ *Diastolic:*______	*Yes:*__________ *No:*__________ *Unknown:*______	Date:_______ *Yes:*________ *No:*_________	Yes:________ *No:*_________	Yes:_______ *No:*________ *N/A:*________	Yes:_______ *No:*________ *N/A:*________	Yes:________ *No:*_________	Yes:________ *No:*_________
		Yes:____ *No:*_____		Yes:____ *No:*_____	Date: __________________ Total Cholesterol: ________ *LDL:* __________________ *HDL:* __________________ *Triglyceride:* __________	Date:________ *Systolic:*______ *Diastolic:*______	*Yes:*__________ *No:*__________ *Unknown:*______	Date:_______ *Yes:*________ *No:*_________	Yes:________ *No:*_________	Yes:_______ *No:*________ *N/A:*________	Yes:_______ *No:*________ *N/A:*________	Yes:________ *No:*_________	Yes:________ *No:*_________
		Yes:____ *No:*_____		Yes:____ *No:*_____	Date: __________________ Total Cholesterol: ________ *LDL:* __________________ *HDL:* __________________ *Triglyceride:* __________	Date:________ *Systolic:*______ *Diastolic:*______	*Yes:*__________ *No:*__________ *Unknown:*______	Date:_______ *Yes:*________ *No:*_________	Yes:________ *No:*_________	Yes:_______ *No:*________ *N/A:*________	Yes:_______ *No:*________ *N/A:*________	Yes:________ *No:*_________	Yes:________ *No:*_________

This form is based on the American Academy of Family Physicians Diabetes METRIC.

Student signature:____ **Date:**_________________________

Reviewed by (faculty signature) _________________________________ **Date:** ________________________