

Diabetes Group Visit - SOAP

St. Peter Family Medicine
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Patient Name _____ DOB _____
 PCP _____ Date _____

S: Patient to Complete

1. What exercises do you do?
 Type _____ How often _____ How long _____
2. How often do you eat the following?

	<u>Never</u>				<u>Always</u>
a. 5 servings of fruit/vegs. a day	1	2	3	4	5
b. Low fat foods	1	2	3	4	5
c. Moderate sized portions	1	2	3	4	5
d. 3 meals a day with healthy snacks	1	2	3	4	5
3. How much stress are you under?

	<u>Low</u>				<u>High</u>
	1	2	3	4	5
4. How satisfied are you with the progress you are making in treating your diabetes?

	<u>Unsatisfied</u>				<u>Satisfied</u>
	1	2	3	4	5
5. Have you quit smoking? Yes No N/A If not, how many packs per day? _____
6. Do you drink alcohol? Yes No If so, how much do you drink? _____
7. What are your blood sugars? Before breakfast _____ 2 hours after dinner _____
 How often do you check? _____
8. Do you check your feet every day? Yes No

O: Chart Review (Provider to Complete)

Medications	Goal/Result/Date (most recent)	Today's Data
<input type="radio"/> _____	BP = (<130/80) _____	Wt: _____
<input type="radio"/> _____	BMI = (<27) _____	Ht: _____
<input type="radio"/> _____	HbA1C = (<8%) _____	BMI: _____
<input type="radio"/> _____	HDL/LDL = (>45/<100) _____	BP: _____
<input type="radio"/> _____	Microalb. = (<35) _____	HR: _____
<input type="radio"/> _____	BUN/Crt. = _____	Foot Exam Score: (Circle)
<input type="radio"/> _____	Foot exam (risk) = _____	Left <u> </u> 0 1 2 3
Allergies: _____	Eye exam = _____	Right <u> </u> 0 1 2 3

Immunizations UTD?: Tetanus Yes No Flu Yes No Pneumo Yes No

A: 1.) Diabetes Mellitus, Type 2 2.) _____ 3.) _____

P: Chart Review/Visit Complete. Recommendations: (Labs, meds, referrals, other...)

SMG Set? Yes No (See CDEMS)

Resident _____ Faculty _____