Midcoast Cardiovascular Associates

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Protecting Your Heart: The Blood Sugar/Insulin Connection

Patient Name: _____ **Date of visit:** _____

_____ (initial) I understand as a participant in this Group Visit/Shared Medical Appointment, that I and other patients will discuss medical information in the presence of other patients, family members, staff, and the clinician. If I have medical concerns that are of a very private nature, I will request to discuss with the clinician in a private setting or will schedule an individual office visit. I will also respect the confidentiality of the other members of the group by not revealing medical, personal, or any other identifying information about others in attendance after the session is over.

CC: ☐ IDDM ☐ NIDDM ☐ Pre-Diabetes ☐ Insulin Resistance/CMS ☐ Other _____

History of Present Illness - Part I *(please complete all sections that apply)*

1. Date (or Year) of diagnosis: _____
   or ☐ Unknown
2. Are you taking your diabetes medication(s) as prescribed?
   - ☐ 100% of the time
   - ☐ Sometimes: _____ % of the time
   - ☐ Never
   - ☐ I do not take medication
3. Do you monitor your fasting/morning blood sugar at home?
   - ☐ Yes, ranges from _____ to _____
   - ☐ No
   - ☐ I was not asked to do so
4. Do you monitor your blood sugar two hours after a meal?
   - ☐ Yes, ranges from _____ to _____
   - ☐ No
   - ☐ I was not asked to do so

Blood Glucose Log	
Fasting (avg):	_____
2 hrs after meals:	_____
Last Hgb A1C:	_____
Date:	_____

Current Lifestyle: History of Present Illness - Part II

1. Tobacco use? _____ cigarettes/cigars per day
2. Alcohol use? _____ drinks per week. Most number of drinks in a given day: _____
3. Caffeine intake? _____ caffeinated beverages per day (include coffee, sodas, energy drinks, etc)
4. Water intake? _____ glasses per day
5. Exercise? ☐ Yes ☐ No

Type of Exercise	Length of Exercise Session	Frequency of Exercise
☐ Walk	> 45 min / 30-45min / < 30 min	_____ x per week
☐ Run, Jog, Bike (brisk aerobic)	> 45 min / 30-45min / < 30 min	_____ x per week
☐ Weight bearing/ lifting	> 45 min / 30-45min / < 30 min	_____ x per week

6. Nutrition & Diet

How often do you eat these foods in a given WEEK? *Choose from: **(4)**Daily – **(3)**Several times per week – **(2)**Once a week or less – **(1)**Never*	
Sugary drinks	
Sweets	

Skip breakfast	
Skip lunch	
Skip dinner	

Review of Systems: *(check all that apply)*

- ☐ Fatigue
- ☐ Palpitations
- ☐ Muscle aches
- ☐ Snoring
- ☐ Weight gain (____lbs last 3 months)
- ☐ Chest Pain
- ☐ Swelling in ankles/legs
- ☐ Headaches
- ☐ Daytime sleepiness
- ☐ Weight loss (_____ lbs last 3 months)

Past Medical History: *(check all that apply)*

- ☐ History of Stroke
- ☐ History of Heart Attack/Stent/Bypass Surgery
- ☐ History of Poor Circulation (peripheral vascular disease)
- ☐ None of the above

Exam:

- Vitals: Wt: _____ Ht: _____ BMI: _____ BP: _____ Pulse: _____ WC: _____
- CV: ☐ R R R; no M/G/R Abnl: _____ Edema: Yes / No JVD: Yes / No
- Respiratory: ☐ CTA B Abnl: _____ Respiratory Effort: Nl Other:

Assessment:

Plan of Care:

☑ Received education on blood sugar imbalance and inflammation relationship ☑ Educated on low glycemic index, blood sugar, anti-inflammation, body composition goals ☑ Recommend exercise or movement therapy as tolerated/as directed ☑ Recommend daily stress management efforts	☐ Provided deep breathing handout for stress management ☐ Directed to keep blood sugar log (fasting and/or 2 hr after meals) ☐ Directed to repeat diagnosis-specific labs every 3 months or as directed ☐ Directed to continue medications as prescribed ☐ Directed to keep blood pressure log ☐ **Return for follow up as directed below:** ☐ Labs first with provider visit after labs are back for review ☐ Same day Provider visit + labs (O fasting O non-fasting) ☐ Provider visit only

Setting and Managing Your Goals

There is so much wisdom in the old saying, "you can't change what you can't measure". Often the simple act of writing down your goals allows you to keep them in the forefront of your lifestyle. Use the chart below to determine the goals you wish to achieve and track your success as you make changes and improve your health. You may even wish to track your lifestyle changes on a weekly basis, moving items from one column to the next to achieve success!

GOALS I WISH TO ACHIEVE	WHAT I AM ACTIVELY CHANGING	WHAT I HAVE ACCOMPLISHED

1.	1.	1.
2.	2.	2.
3.	3.	3.
4.	4.	4.