



Diabetes








Self management goals

Patient name _____
Date of birth _____
Daytime phone # _____
Address _____
City/State/Zip _____
Today's date _____

Follow up time frame:

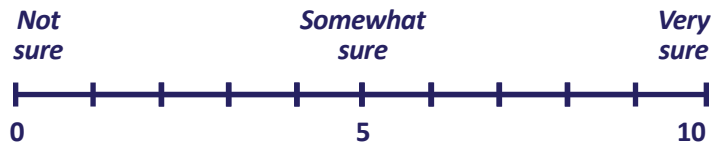
Goal setting

Please choose goals you would like to work on to better manage your diabetes.

-  I will exercise (walk) 30 minutes _____ days per week. If I notice chest pain, shortness of breath, or chest tightness, I will seek medical attention.
-  I will check my feet daily. If I notice a sore or irritation I will seek medical attention. I will visit the Podiatrist yearly, or as instructed.
-  I will follow my diabetic and low fat diet to reduce my blood sugar and cholesterol.
-  I will try to obtain my ideal body weight. I will lose _____ pounds by my next office visit.
-  I will stop smoking.
-  I will have an eye exam every year or as indicated.
-  I will check my blood sugar _____ times a day and will call if the results are consistently below _____ or above _____. (ADA recommendation is to maintain a blood sugar level between 80 and 130.)

2. Choose your confidence level:

I think I can succeed at this goal:



3. Fill in the following for your chosen goal:

What: _____

When: _____

How much: _____

How often: _____

Barriers to meeting these goals: _____

Clinician signature

