Chronic Disease Clinic Follow-Up

List chronic diseases:

1) 3) 5)  
2) 4) 6)  

Attach pharmacy profile or list current medications:

Subjective:

Asthma: # attacks in last month?_______  
# short acting beta agonist canisters in last month?_____  
# times awakening with asthma symptoms per week?_______  
Seizure disorder: # seizures since last visit?_______  
Diabetes mellitus: # of hypoglycemic reactions since last visit?_______  
Weight loss/gain ↓↑ #lbs  
CV/hypertension (Y/N): Chest pain?_______  
SOB?_____  
Palpitations?_____  
Ankle edema?_____  
HIV/HCV (Y/N): Nausea/vomiting?_______  
Abdominal pain/swelling?_____  
Diarrhea?_____  
Rashes/lesions?_______  

For all diseases, since last visit, describe new symptoms:

Patient adherence (Y/N): with medications?_______ with diet?_______ with exercise?_______

Vital signs: Temp_______ BP_______ Pulse_______ Resp_______ Wt_______ PEFR_______ INR_______

Labs: Hgb A1C_______ HIV VL_______ CD4_______ Total Chol_______ LDL_______ HDL_______ Trig_______

Range of fingerstick glucose/BP monitoring: ____________________________

PE:

HEENT/neck: Extremities:  
Heart: Neurological:  
Lungs: GU/rectal:  
Abdomen: Other:

Assessment:

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<th>Degree of Control</th>
<th>Clinical Status</th>
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Plan:

Medication changes: ____________________________

Diagnostics: ____________________________

Labs:

Monitoring: BP:_______ X day/week/month  
Glucose:_______ X day/week/month  
Peak flow:_______  
Other:_______

Education provided: [ ] Nutrition  [ ] Exercise  [ ] Smoking  [ ] Test results  [ ] Medication management  [ ] Other:_______

Referral (list type): Specialist:_______  
Chronic care program:_______

# days to next visit: 90 [ ] 60 [ ] 30 [ ] Other:_______  
Discharged from CCC: [name]_______

Advance Level Provider Signature: ____________________________ Date:__________________________

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