

Manage Your Diabetes

With These Important Tests and Exams

Test every

3 MONTHS

A1C Tests*

The A1C test gives you a picture of your average blood glucose (blood sugar) control for the past 2-3 months.

Ask your doctor about your goal.



Test every

12 MONTHS

Cholesterol Tests*

Have your cholesterol checked every year, or more often if recommended by your doctor.

Discuss with your doctor the need for cholesterol lowering medications (Statin therapy).

Test at

EACH DOCTOR VISIT

Blood Pressure*

Diabetes may increase your risk of developing high blood pressure.

Ask your doctor about your goal.



Test every

12 MONTHS

Kidney Tests

Kidney monitoring is an important part of diabetes care. Your provider should check your blood and urine for signs of kidney disease.



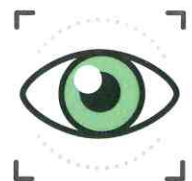
Test every

12 MONTHS

Eye Exams

You should have an annual retinal eye exam, no matter how short a time you have had diabetes. More frequent exams may be needed if you have eye disease.

This exam is allowed yearly under your medical benefit based on your condition.



Stay active and involved in your health care. Be your own health hero.

Visit www.cdphp.com/diabetes for more information and tips.

**Individual goals may vary. Speak with your doctor to determine yours.*

Source: American Diabetes Association



Take Charge of Your Diabetes

This list of items for proper diabetes care is recommended by the American Diabetes Association (ADA) and the NYS Department of Health's Diabetes Prevention and Control Program. Take this to your doctor and diabetes educator visits so you can take charge of your diabetes. Write in your **numbers** and place a check mark in the column for the items completed.

Tests (How often)	ADA Goal	My Goal	Month of Visit											
			Jan.	Feb.	Mar.	April	May	June	July	Aug.	Sep.	Oct.	Nov.	Dec.
Hemoglobin A1C* (every 3 months)	Below 7%													
Blood Pressure* (each visit)	Below 130/80													
Cholesterol (yearly)	TOTAL	Discuss goals with your doctor												
	LDL													
	HDL													
Triglycerides (yearly)														
Weight														
Height														
Completed (mark boxes below when complete)														
Eye Doctor's Name and location														
Retinal Eye Exam (yearly)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine Test for Kidney Function (yearly)														
Blood Test for Kidney Function (yearly)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foot Exam (each visit)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Exam (every 6 months)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu Vaccine (yearly)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia Vaccine (discuss schedule with doctor)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Lowering Medication (Statin)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*Individual goals may vary. Speak with your doctor to determine yours.