1. IDENTIFICATION

Medical Doctor

Name: ________________________________
Phone: ________________________________
E-mail: ________________________________

2. CURRENT CLINICAL and BIOLOGICAL CHARACTERISTICS

a. Weight: ___ kg   Height: ___ cm
b. Systolic blood pressure: ___ mmHg
c. Diastolic blood pressure: ___ mmHg
d. Last HbA1c: ___%
e. LDL cholesterol: ___ mmol/L or ___ g/l
f. HDL cholesterol: ___ mmol/L or ___ g/l
g. Triglycerides: ___ mmol/L or ___ g/l
h. No or only mild non proliferative retinopathy: yes: ___  no: ___
i. Moderate or severe non proliferative retinopathy: yes: ___  no: ___
j. Proliferative retinopathy: yes: ___  no: ___
k. Photocoagulation: yes: ___  no: ___  ➔ If yes, year of first treatment: ______
l. Macular edema: yes: ___  no: ___
m. Low vision (≤ 6/20 for the better eye): yes: ___  no: ___
n. Cataract surgery: yes: ___  no: ___
o. Creatinine: ___ μmol/L or ___ mg/l
p. Micro or macroalbuminuria: yes: ___  no: ___
q. Followed by a nephrology specialist: yes: ___  no: ___
   ➔ If yes: Dialysis: yes: ___  no: ___  ➔ If yes, year of beginning: ______
   Renal transplant: yes: ___ no: ___
r. High blood pressure treatment: yes: ___  no: ___
s. History of angina, myocardial infarction, angioplasty with or without stents, coronary bypass: yes: ___ no: ___  If yes, year of first event: ______
t. History of peripheral arteriopathy, angioplasty with or without stents, bypass of lower limbs arteries: yes: ___ no: ___  ➔ if yes, year of first event: ______
u. History of stroke: yes: ___ no: ___  ➔ If yes, which year? ______
v. History of foot ulcers: yes: ___ no: ___
w. History of amputation: yes: ___ no: ___
x. Cognitif disorders: yes: ___ no: ___