

Diabetes Mellitus Nursing Care Plan

Patient information	
Name:	Age:
Gender:	
Medical history	
<div><input type="checkbox"/> Family history of diabetes</div> <div><input type="checkbox"/> History of gestational diabetes</div> <div><input type="checkbox"/> Recent history of elevated blood glucose levels</div> <div><input type="checkbox"/> Use of oral medications for diabetes</div> <div><input type="checkbox"/> Current insulin therapy (e.g., insulin injections or continuous subcutaneous insulin infusion)</div> <div><input type="checkbox"/> Others (Please specify):</div>	
Assessment	
Subjective data	Objective data
<div><input type="checkbox"/> Reports of increased thirst and urination</div> <div><input type="checkbox"/> Complaints of blurred vision</div> <div><input type="checkbox"/> Fatigue and weakness</div> <div><input type="checkbox"/> Numbness or tingling in extremities</div> <div><input type="checkbox"/> Reports of high blood sugar</div> <div><input type="checkbox"/> Difficulty adhering to blood glucose monitoring schedule</div> <div><input type="checkbox"/> Others (Please specify):</div>	<div><input type="checkbox"/> Blood glucose level outside target range</div> <div><input type="checkbox"/> Abnormal lab values (e.g., HbA1c, fasting glucose)</div> <div><input type="checkbox"/> Elevated blood pressure</div> <div><input type="checkbox"/> Signs of dehydration (dry skin, low urine output)</div> <div><input type="checkbox"/> Others (Please specify):</div>
	Vital signs
	Heart rate:
	Blood pressure:
	Respiratory rate:
	Temperature:

Nursing diagnosis	
Goals and outcomes	
Short-term	Long-term
Nursing interventions	
Rationale	

Evaluation
Additional notes
Nurse's information
Name:
License number:
Contact number: