Diabetes and your eyes

You can protect your vision!

It’s important to take care of your eyes when you have diabetes. Diabetes can affect your eyes. But there is a lot you can do to keep your eyes healthy. Take these steps, recommended by the American Diabetes Association:

**Keep your blood sugar as close to your target levels as possible**

- Research shows that the better your blood sugar control, the less likely diabetes-related eye problems are to happen

**Keep your blood pressure within your diabetes goal range**

- High blood pressure can make eye problems worse by damaging the tiny blood vessels in your eyes
- Have your blood pressure checked at every visit with your diabetes care team
- If it is too high, talk with your team about what you can do to lower it

**Quit smoking**

- Like high blood pressure, smoking damages the tiny blood vessels in your eyes. It also increases pressure inside your eyes
- You don’t have to do it alone. Ask your diabetes care team for help to stop smoking

See your eye care professional at least once a year for a dilated eye exam—even if your vision seems fine

- Having your regular doctor look at your eyes is usually not enough
- During your dilated eye exam, your eye care professional may use eye drops to enlarge your pupils. This will help him or her to see more of the inside of your eyes. He or she will also use a special magnifying lens to look at your eyes
- Your eye care professional will also check
  - The pressure in your eyes
  - Your side, or peripheral, vision
  - How well you can see at various distances

Make sure that your eye care professional sends the results of your eye exam to your diabetes care team.
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See your eye care professional right away if:

- Your vision becomes blurry
- You have difficulty reading signs, books, or newspapers
- You are having double vision
- You have pain in one or both of your eyes
- Your eyes get red, and the redness doesn’t go away
- You feel pressure in your eyes
- You see spots or floaters before your eyes
- When you look at straight lines, they don’t look straight
- Your peripheral vision (your ability to see things at the sides) is not as clear as it was

Keep track!

Use the spaces below to keep track of your eye exams.

Name of eye care specialist: ________________________________________________________________

Phone number: __________________________________________________________________________

Fax number: _____________________________________________________________________________

Date of last exam: ________________________________________________________________________

Findings: ______________________________________________________________________________

Recommended follow-up: __________________________________________________________________

Results sent to diabetes care team? ☐ Yes ☐ No
Enroll today to get FREE, personalized diabetes support with Cornerstones4Care®.

Support and diabetes management tools built around you.

- Diabetes Health Coach
  An online program that builds a customized action plan around your needs to help you learn healthy habits
- Meal Planning Tools
  Create tasty, diabetes-friendly meals
- Interactive Trackers
  Record A1C, weight, and blood sugar numbers

Enrolling is easy. Just complete this form.

All fields with asterisks (*) are REQUIRED.

- I have diabetes or I care for someone who has diabetes
- First name ____________  Last name ____________  MI _____
- Address 1 ____________________________________________
  Address 2  ____________________________________________
- City ___________________  State ________________________
- ZIP _________________  Email _________________________
- Birth date mm/dd/yyyy / /

What type of diabetes do you or the person you care for have? (Check one)
- Type 2
- Type 1
- Don’t know

What type of diabetes medicine has been prescribed? (Check all that apply)
- Insulin
- GLP-1 medicine
- None
- Other
- Diabetes pills (also called oral antidiabetic drugs, or OADs)

If you checked “Insulin,” “GLP-1 medicine,” or “Other,” please fill in the following for each:

Product 1: ___________________________________
  How long has this product been taken?
  - Prescribed but not taken 7-12 months
  - 0-3 months 1-3 years
  - 4-6 months 3 or more years

Product 2: ___________________________________
  How long has this product been taken?
  - Prescribed but not taken 7-12 months
  - 0-3 months 1-3 years
  - 4-6 months 3 or more years

3 easy ways to enroll:
1. Fax the completed form to 1-866-549-2016
2. Email the completed form to C4Csignup@hartehanks.com
3. Call 1-888-825-1518 and follow the voice prompts

Review and complete below.

* Phone number:
  (______) _______ – __________
* Cell phone number:
  (______) _______ – __________

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I understand from time to time, Novo Nordisk’s Privacy Policy may change, and for the most recent version of the Privacy Policy, please visit www.C4CPrivacy.com.

By signing and dating below, I consent that the information I am providing may be used by Novo Nordisk, its affiliates or vendors to keep me informed about products, patient support services, special offers, or other opportunities that may be of interest to me via mail and email. Novo Nordisk may also combine the information I provide with information about me from third parties to better match these offers with my interests. These materials may contain information that market or advertise Novo Nordisk products, goods, or services.

* Yes, I’d like to be contacted by Novo Nordisk via phone calls and text messages at the phone numbers I have provided.

By checking this box, and signing and dating below, I authorize Novo Nordisk to use auto-dialers, prerecorded messages, and artificial voice messages to contact me. I understand that these calls and text messages may market or advertise Novo Nordisk products, goods, or services. I understand that I am not required to consent to being contacted by phone or text message as a condition of any purchase of goods or services.

I may opt out at any time by clicking the unsubscribe link within any email I receive, by calling 1.877.744.2579, or by sending a letter with my request to Novo Nordisk Inc., 800 Scudders Mill Road, Plainsboro, New Jersey 08536.

By providing my information to Novo Nordisk and signing and dating below, I certify I am at least eighteen (18) years of age and agree to the terms above.

* Signature ____________________________
  (required)
* Date (required) ____________
  mm/dd/yyyy

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