Zenu Center For Endocrinology, Metabolism and Weight Management

Patients: _____ Date of Birth: _____

Drug Allergies/Sensitivities: _____

Emergency Phone #: _____ Contact Person/Relationship: _____

ICD Code	Chronic Medical Problem List	Date	Past Surgical History	Date
			Hospitalizations	**Date**

Family History of

Y	N		Family Member
☐	☐	Alzheimer's Dz	_____
☐	☐	Breast Ca	_____
☐	☐	CAD	_____
☐	☐	Cerebrovas. Dz	_____
☐	☐	Depression	_____
☐	☐	Diabetes	_____
☐	☐	Fe Storage	_____
☐	☐	Glaucoma	_____
☐	☐	High Cholesterol	_____
☐	☐	HTN	_____
☐	☐	Thyroid	_____

Diabetes Assessment

	Date
☐ Ophthalmology Appt	_____
☐ Podiatry Appt	_____
☐ Depression	_____
☐ Osteoporosis	_____

Habits

☐ Smoking

If yes: specify quantity/day _____

☐ Alcohol

If yes please specify quantity/day

Diet Restrictions: _____

Social History

☐ Married ☐ Single ☐ Civil Union

☐ Divorced ☐ Widow (er)

☐ Lives Alone ☐ Separated

Occupation: _____

Religious Preference: _____

Advance Directive? ☐ Yes ☐ NO

If Yes, Date: _____

Education: ☐ JHS ☐ HS ☐ College

☐ Other _____

Signature: _____

Date: _____

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