Hancock Diabetes and Endocrine Center, Pllc.....Dr Llyod Hancock

Patient's Name: _____ Date of Birth: _____/_____/_____

What is the reason for your visit? _____

Other Medical Conditions: _____

_____

_____

_____

_____

Past Surgical Procedures: _____

_____

_____

_____

_____

Family History: (please check all that apply)

( ) Diabetes ( ) Heart Disease ( ) Stroke ( ) High Blood Pressure ( ) Kidney Disease ( ) Cancer ( ) Thyroid

Social History: (please check all that apply)

- Marital Status: ( ) Married, ( ) Single, ( ) Divorced, ( ) Widow, ( ) Separated
- Number of Children: _____
- Tobacco Products: ( ) Yes, ( ) None, ( ) In the Past only
- Years using tobacco: _____ How many Packs per day? _____
- Do you drink alcohol? ( ) No, ( ) Yes: ( ) Rarely, ( ) Occasional, ( ) Daily
- What is the last Level of education completed? _____,
- Are you currently: ( ) Employed, ( ) Unemployed, ( ) Retired, ( ) Disabled

Please List all medications, the strength, and how often you take the medication:

(You can continue on the back if not enough room is permitted. You may also bring in a list that you already have made.)

Name:	Strength:	Times per day:

Please List all Food/ Drug allergies: _____

_____

Please check all symptoms that you have experienced in the last 2 weeks:

( ) Weight gain, ( ) Weight loss, ( ) fatigue/ tired, ( ) insomnia, ( ) Recent illness ( ) chest pain,
( ) swelling in legs/ hands, ( ) heart flutters, ( ) Shortness of breath, ( ) Cough, ( ) asthma,
( ) Abdominal pain, ( ) Gas/ Bloating ( ) Diarrhea, ( ) Constipation, ( ) Trouble Swallowing, ( ) Dizzy,
( ) Headache, ( ) Arm/ Leg pain, ( ) Anxiety,( ) Depression, ( ) Loss of memory