Hope Diabetes Center Corporate — a Drop of Life

Patient Name: _____ **Date of Birth:** _____
Allergies: _____

Adv. Directive: ☐ DNR ☐ Full Code ☐ Modified Code; **Living Will:** Yes ☐ No ☐; **HIPPA [Date]:** _____

Social Problem List			advised to quit		Date Quit
Issue	Yes	No	Yes	No	
Smoking					
Alcohol					
Drugs					

Chronic Problem List

Code	#	PROBLEM	Code	#	PROBLEM
	1			11	
	2			12	
	3			13	
	4			14	
	5			15	
	6			16	
	7			17	
	8			18	
	9			19	
	10			20	

Family History

Non Contributory DM HTN CHL RAD CA Other:

Health Promotion Profile

Complete Physical Exam									
Eye Exam	Recommended **Yes** ☐ **No** ☐								
HbA1c	Level								
	Date								
Cholesterol									
Fecal Occult Blood	Recommended **Yes** ☐ **No** ☐								
Urinalysis									
Rectal/Prostate Exam	Recommended **Yes** ☐ **No** ☐								
PSA	Level								
	Date								
Pelvic/Pap/Rectal	Recommended **Yes** ☐ **No** ☐								
Mammogram	Recommended **Yes** ☐ **No** ☐								
EKG / Doppler / Bone Densi									
Influenza Vaccine	Recommended **Yes** ☐ **No** ☐								
Tetanus	Recommended **Yes** ☐ **No** ☐								
Pneumovax	Recommended **Yes** ☐ **No** ☐								