Patient Information Form

Patient Name: (Last)_____(First)_____(MI)____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Beeper/Cellular: _____

Birthdate: _____Age: _____Sex: M F

E-Mail Address:_____

Do you have health insurance? Yes or No Name of insurance: _____

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____Ext. _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Weight Loss & LipoSise @ CMC for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Personal / Family / Medical History

(please check if you (self) or any blood relative has or has had any of the following conditions
Please indicate which relative:

relative	self	
		Abdominal pain
		Accident (major)
		Alcoholism/Drug addiction
		Allergy (food, medicine, animals, etc.)
		Anemia
		Anorexia
		Anxiety/Nervous breakdown
		Arthritis
		Asthma
		Bad taste in mouth
		Back pain
		Belching / Burping
		Bladder problems
		Bleeding (unusual)
		Blood / Pus / Stones / Sugar in urine
		Blood transfusion
		Bulimia
		Chest pain
		Cancer / Tumor
		Constipation
		Cough (frequent or chronic)
		Depression
		Diabetes
		Dry skin
		Eczema
		Epilepsy / Seizures
		Food allergy
		Fainting spells or dizziness
		Gall stones
		Gland problems
		Gastritis
		Goiter
		Gout
		Hair loss
		Headache/Migraine
		Heartburn / Bloating / Hiatal hernia
		Heart disease
		Hemorrhoids
		Hepatitis
		High blood pressure
		High cholesterol
		HIV/AIDS
		Hot or cold flashes
		Increased urination
		Irritable bowel syndrome
		Joint or muscle aches
		Jaundice
		Kidney disease
		Liver disease
		Lung disease
		Memory lapses
		Mental illness
		Nail or cuticle problems
		Nausea / Vomiting
		Neurological disorder
		Osteopenia/Osteoporosis
		Pain or burning with urination
		Palpitations
		Paralysis
		Pneumonia
		Poisoning/Medication overdose
		Recent change in bowel habits
		Recurrent colds (more than 5 per year)
		Ringing or buzzing in ears
		Rheumatic fever
		Sexually transmitted disease
		Sleep problems
		Shortness of breath
		Sinus trouble
		Stomach / Intestine / Colon disorder
		Swollen Legs/Ankles/Feet/Hands(chronic)
		Stroke
		Thyroid disease
		Tuberculosis
		Unusual, frequent, or increasing thirst
		Vision or eye problems
		Varicose veins

Please elaborate on any medical or psychological problems listed and/or not listed above

Are there any emotional or personal situations that you would like us to be aware of?

Surgical History

Date	Operation

Hospitalizations

Date	Illness / Injury

Family History

Father *(if deceased)* Age Cause of death

Mother *(if deceased)* Age Cause of death

Reviewed by Physician_____

Social History

Do you smoke or use any tobacco products? Y N
Do you use any illegal or street drugs? Y N
How many hours of sleep do you get on an average night? _____
Do you work a night shift? Y N
If so, how many nights per week? _____

Medications

Name	Dose

Allergy History (please list any allergy you have had; including food, medication, seasonal, environmental, etc.)

Gynecolcgic History (women only)

Have your periods stopped? Y N
Are your periods irregular? Y N
Do you have pain and cramping? Y N
Age when your period began? _____

How many days between periods? _____

How many pads/tampons used daily? _____

Approximate dates of last 3 periods _____ _____ _____

Have you been diagnosed with Polycystic Ovarian Syndrome? Y N
Are you pregnant now? Y N
Do you plan on becoming pregnant? Y N

How many times have you been pregnant? _____

How many live births have you had? _____

Please give all relevant dates and information regarding any problem births, abortions, still borns, miscarriages, caesareans, or other complications you have experienced

_____
_____
_____
_____

Vitamins, Minerals & Supplements

Name

Dietary, Weight, and Exercise History

How much did you weigh at this time last year? _____

Which best describes the eating philosophy of your parents?

1. Eat until you are no longer hungry
2. Eat until you are full
3. Clean your plate

What best finishes the statement "My refrigerator and pantry are full of..." *(circle all that apply)*

1. Fruit, nuts, water, yogurt, sugarless snacks, low fat milk, sugarless drinks
2. Chips, candy, soda, cake, mayonnaise, whole milk
3. A combination of 1. and 2.

Have you ever had an eating disorder? Y N
If yes, what type? _____
_____
_____

What medications or supplements have you taken in the past in an attempt to lose weight? *(please list all)*

_____
_____
_____

What other diets have you tried in the past? Tell us about your experience(s). _____
_____
_____
_____
_____

How many hours of TV do you watch each week? _____

What types of exercise do you currently do and how often?

_____
_____
_____
_____
_____
_____

Reviewed by physician _____

Activity Level (pick one)

_____ Inactive - no regular physical activity
_____ Light - usually during leisure time
_____ Moderate - occasional activity on weekend
_____ Heavy - lifting, stair climbing, sports 3 times/week
_____ Vigorous - extensive exercise for 60 min. 4 times/week

What condition, situation, factors and/or behavior (e.g. pregnancy, stress induced eating, night time snacking, etc.) contributed to your weight gain?

List previous diets you have tried and include dates & results of weight loss.

Do you feel out of control while eating? Y N
If so, which foods?

If you have lost weight, and then regained, please indicate the 3 most important reasons for the weight gain:

_____ less exercise
_____ infrequent clinic visits
_____ lack of support
_____ stress
_____ stopped weight checks
_____ overeating at meals
_____ socializing
_____ depression
_____ lack of planning
_____ other _____

What do you find is the most difficult about managing your weight?

What do you believe will be of most help to assist you in losing weight?

How confident are you that you can lost weight at this time?
Confident 4 3 2 Not confident

How much support can your friends provide?
Support 4 3 2 No support

How much support can your family provide?
Support 4 3 2 No support

Do you follow a special diet?

_____ No
_____ Low fat
_____ Diabetic
_____ Other
_____ Kosher
_____ Low sodium
_____ Vegetarian

If other, please specify:

Which meals do you regularly eat?

_____ Breakfast
_____ Brunch
_____ Lunch
_____ Dinner

When do you usually snack?

_____ Morning
_____ Afternoon
_____ Evening
_____ Late Night
_____ Throughout day
_____ Never

What are your common snack foods?

Do you usually eat out or order food in? Y N
How often? Daily Weekly Monthly Other

How is your food usually prepared? (pick all that apply)

_____ Baked
_____ Steamed
_____ Boiled
_____ Broiled
_____ Poached
_____ Fried

What beverages do you drink daily and how much?

Water _____ times or 8oz glasses per day
Coffee _____ times or cups per day
Tea _____ times or cups per day
Soda _____ times or 12oz glasses per day
Alcohol _____ times or 12oz glasses per day
Other _____ times or glasses per day
Specify _____

How many times each day do you have the following?

1. Starch (bread, bagel, cereal, pasta, rice, potatoes)
Never < 1 1-2 3-5 6-8 9-11

2. Fruit
Never < 1 1-2 3-5 6-8 9-11

3. Vegetables
Never < 1 1-2 3-5 6-8 9-11

4. Dairy (milk, yogurt)
Never < 1 1-2 3-5 6-8 9-11

5. Fat (butter, mayo, oil, sour cream, cream cheese, ice cream)
Never < 1 1-2 3-5 6-8 9-11

6. Sweets (candy, cake, regular soda, juice)
Never < 1 1-2 3-5 6-8 9-11

7. Protein (Meat, fish, poultry, eggs, cheese)
Never < 1 1-2 3-5 6-8 9-11

Reviewed by physician _____