Patient Information

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

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

Birthdate: _____Age: _____Sex: M F

Patient Employer: _____ Occupation: _____

Work phone No: _____Driver's License#: _____

Email Address: _____

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

NUTRITION HISTORY

Do you frequently skip meals? Yes _____ No _____
If yes, which ones? Breakfast _____ Lunch _____ Dinner _____
Who plans meals? _____ Cooks? _____ Food shops? _____
How many times per week do you eat in a restaurant? 0-2_____ 3-5_____ 6 or more_____
How many times per week do you eat fast foods? 0-2_____ 3-5 _____ 6 or more _____
How often are the following meals eaten out? Breakfast _____ Lunch _____ Dinner_____
How often do you snack between meals? _____
What are the foods you crave the most? _____
What are your worst food habits? _____

EMOTIONAL/BEHAVIORAL ISSUES

Are your physical activities restricted for any medical reasons?
_____
If yes, list reasons:
_____
Have you ever diagnosed with an eating disorder? _____ If yes, when? _____
Where? _____
Treatment_____
What feelings or situations trigger you to eat even though you are not hungry?

____ Anger	____Celebrations	____Loneliness
____Anxiety/ nervousness	____ Depression	____Stress
____Boredom	____ Family gatherings	____ Social situations

Do you struggle with binge eating? Frequently _____ Occasionally _____ Rarely _____
Are there any personal problems/ situations you have experienced or anticipate experiencing (i.e. relationships, job changes) that may affect your weight loss efforts? Yes _____No _____ if yes, explain
_____
Have you ever been treated for a psychiatric diagnosis, including drug or alcohol addiction? Yes _____
No _____ If yes, what was the diagnosis?
_____
What was the treatment? _____

Were you overweight as a child? Yes_____No _____
Are any of the following family members overweight? Spouse_____ Mother_____ Father_____
What is your goal weight (i.e. realistic, healthy weight)? _____
Which of the following weight loss programs have you tried?
__Diet Center __Weight Watchers __Nutri-system __Jenny Craig __Own program __R.D. Counseling
__Liquid Diet__ Overeaters Anonymous __ Physician Program __ Other If other, please describe_____
How motivated are you to lose weight? __Extremely __Moderately __Somewhat __A little
How committed are you to making lifestyle changes? __Extremely __Moderately __Somewhat __A little

Social History

Do you drink any alcohol?_____If so, how often?_____
Do you smoke?_____ If so, how often and how much_____

Symptoms

Are you experiencing any of the following? Check all that apply:

__ Glaucoma	__Nausea	__Seizures/ convulsions
__Abdominal pain	__Vomiting	__Numbness or tingling
__Heart Disease	__Diarrhea	__Fainting
__Chest pain	__Constipation	__Heat & cold intolerance
__Irregular heart beat	__Jaundice	__Excessive thirst
__Swelling of ankles/feet	__Polycystic ovary disease	__Sudden weight gain/loss
__Circulation deficiency	__ Pain/swelling in joints	__Frequent Urination
__Fainting	__Back/neck pain	__Increased appetite
__Shortness of Breath	__Rashes	__Anemia
__Wheezing	__Dizziness	__Weak with minimal exercise
__Indigestion	__Severe Headaches	__Tender swollen lymph nodes

Are you or can you possibly be pregnant right now? _____

FAMILY HISTORY

Please include if there is a history of diabetes, high blood pressure, cancer, coronary heart disease or obesity among relatives in your family.

		Use this column if living	Use this column if deceased	
Relative	**Age**	**State of Health/medical problems**	**Cause of Death**	**Age**
Father				
Mother				
Brothers				
Sisters				
Spouse				
Comments				

Medical History

Who is your Physician?

_____
Who are your Specialists? _____
Do you have any of the following illnesses?

__GLAUCOMA	**__P.C.O.S (polycystic ovary syndrome)**	**__Addiction to any**
__SLEEP APNEA	**__Kidney Failure**	**other drug**
__HEART DISEASE	**__Kidney Stones**	**__Eating disorder**
__Heart Rhythm Problems	**__Gout**	**__Anorexia/ Bulimia**

__ASTHMA
__COPD/Emphysema
__Smoking addiction
__GERD
__Crohn's Disease
__Colitis
__Stomach
__Ulcers
__Obesity
__Gall Stones
__Hypertension
__ARTHRITIS
__Lupus
__Fibromyalgia
__Scoliosis
__PSORIASIS
__STROKES
__Headaches
__Migraines
__Neuropathy
__ADDICTION TO ALCOHOL
__Bipolar Disorder
__Depression
__Anxiety
__DIABETES
__Hyperthyroidism
__Hypothyroidism
__Hyperlipidemia
__Hypercholesterolemia
__ANEMIA
__Cancer

SURGICAL HISTORY

Have you had any Gastric Surgeries?
If yes, which one, when was the operation performed and the name of the Physician who performed the procedure?

Year	**Operation**	**Physician**
_____	_____	_____
_____	_____	_____

Do you have any drug or food allergies? _____If so what kind?_____

Please List All medication you are taking at this present time. (Including nonprescription) Vitamins etc.

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
Signature: _____ (Patient)
Signature: _____ (Physician)

Financial Policy:

Thank you for selecting Dr. _____ 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