

REGISTRATION FORM – *Adult Version*

(Please Print)

PATIENT INFORMATION

Patient's last name:		First:	Middle:	Marital status (circle one)		
					Single / Married / Divorced / Separated / Widowed	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Former name (Maiden name):		Birth date:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security #:		Phone #:	
City:		State:	Zip code:		Email:	
Employer:		Employers Address:		Employment Status: FT / PT / NA	Employer phone #:	
Spouse Name:		Spouse Birth date:	Spouse Employer:		Spouse Employment Status: FT / PT / NA	
Next of Kin's Name:		Next of Kin's Address:			Next of Kin Phone #:	
Family Doctor's Name:			Referring Doctor's Name:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:		Birth date:	Address (if different from above):		Phone #:
Employer:	Status: FT / PT / NA	Employer address:			Employer phone #:
Primary insurance:				Effective Date:	
Insured's name:	Insured's Social Security #:	Birth date:	Policy #:	Group #:	Co-payment: \$
Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Insured's name:	Policy #:	Group #:	
Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
How did you find us? (Please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages					
<input type="checkbox"/> Close to home/work <input type="checkbox"/> Advertisement <input type="checkbox"/> Other					

If Patient is a minor, please complete the following:

Mother's name:		Father's name:	
Mother's Address:		Father's Address:	
Mother's Phone #:		Father's Phone #:	
Mother's Employer:		Father's Employer:	
Mother's Work Phone #:		Father's Work Phone #:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone #:	Work phone #:
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This information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize LVHNN or insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

Patient Name _____

Body Weight: _____ Height: _____

BMI: _____ % Body Fat _____ Ideal Body Weight: _____ <i>Calculated by WMC</i>

WEIGHT HISTORY

Please estimate as closely as possible for all that applies.

Life Event	Age	Weight
High School Graduation		
Marriage		
Lowest Weight in Past 5 Years		
Highest Weight in Past 5 Years		

What has triggered your weight gain? _____

What has been an obstacle to your weight loss in the past? _____

What is your goal weight? _____

DIETARY HISTORY

Approximate age when you first seriously dieted:

Check the diets and diet programs you have tried:

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Jenny Craig					
Nutri-System					
Weight Watchers					
OptiFast					
MediFast					
Fen/Phen/Redux					
Meridia					
Xenical					
T.O.P.S.					
Overeaters Anonymous					

Patient Name _____

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Acupuncture					
Metabolife					
Herbalife					
Atkins Diet					
South Beach Diet					

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

FOOD PREFERENCES

List your 10 favorite foods (imagine all are equal in calories!)

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

24 HOUR FOOD RECALL

List all foods and beverages you eat in one day with the approximate time. Try to give specific amounts of food eaten and tell how the food was prepared (example- 1/2 cup baked potato with 1 tsp. butter).

Breakfast	Time	Lunch	Time	Dinner	Time
Snack		Snack		Snack	

WEIGHT RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes No

If Yes: Year Diagnosed _____

Do you have, or have you had:

- Angina Congestive Heart Failure
- Heart Attack Abnormal EKG
- Stress test to rule out cardiac problems Palpitations

Office Use: Cardiology Consult

2. High Cholesterol Yes No High Triglycerides Yes No

If Yes: Year Diagnosed _____

List medications _____

3. High Blood Pressure Yes No

If Yes: Year Diagnosed _____

List medications _____

4. Diabetes Yes No

If Yes: Year Diagnosed _____

Gestational: Yes No

Neuropathy: Yes No

Controlled with: Diet

Oral medication (list) _____

Last fasting blood sugar: _____

5. For females only, do you have polycystic ovarian syndrome? Yes No

6. Asthma Yes No

If Yes: Year Diagnosed _____

ER visits last 2 years? Yes No

Hospitalizations last 2 years? Yes No

Steroids last 2 years? Yes No

Office Use: Pulmonary Consult

7. Shortness of Breath Yes No

If Yes: Can walk: _____ (How far?)

Stairs: _____ (How many?)

8. Trouble Sleeping? Yes No

Morning headaches Yes No

Daytime drowsiness Yes No

Restless sleep Yes No

Snoring Yes No

Awakenings at night Yes No

Observed apneas Yes No

Office Use: Sleep Study Ordered

9. Sleep Apnea Syndrome Yes No

If Yes: Year Diagnosed: _____

Last sleep study: _____ month/year

CPAP used: Yes No

10. Heartburn/esophagitis/hiatus hernia? Yes No

If Yes: Year Diagnosed: _____

Upper GI series? Yes No

Endoscopy? Yes No

Medications: _____

Frequency of use: _____

11. Belching up acid or sour fluid? Yes No

12. Coughing or choking at night? Yes No

13. Gallbladder disease? Yes No

If Yes, how was it diagnosed? Ultrasound Physical Exam

Office Use: UGI/Endoscopy

14. Leakage of urine with laughing/coughing/sneezing? Yes No

If Yes, wear pads frequently? Yes No

Office Use: Incontinence Consult

15. Low back train/pain/sciatica? Yes No

Orthopedic Surgeon? Yes No

Seen by family doctor? Yes No

Medications taken _____

16. Pain in hips/knees/ankles/feet? Yes No

If yes, seen by Chiropractor? Yes No

Orthopedic Surgeon? Yes No

Seen by family doctor? Yes No

Medications taken _____

17. Do you have arthritis? Yes No

18. Weight related injuries and trauma: _____

19. Do you have Venous Stasis Disease? Yes No

If yes, do you have lower leg swelling? Yes No

Scaly & thick skin? Yes No

Leg ulcers? Yes No

20. Do you have gout? Yes No

If yes, gouty arthritis? Yes No

Medications taken _____

21. Bra size (females only);

Skin depressions from bra straps? Yes No

Do you have shoulder pain: Yes No

22. Behavioral health

- Are you on any anti-depressant medication? Yes No
- Were you hospitalized for depression? Yes No
- Do you have any other behavioral health issues? Yes No explain _____

23. Coping with weight management

- Do you feel sad more often than usual? Yes No
- Do you find yourself getting irritated or angry about little things? Yes No
- Are you getting less enjoyment out of life activities than you would like? Yes No
- Do you often feel tired? Yes No
- Do you have trouble concentrating? Yes No
- Do you ever feel worthless, like life isn't worth living? Yes No
- Do you believe you are depressed? Yes No
- Are you under emotional or personal stress right now? Yes No
- Are you interested in meeting with our social worker to learn new strategies to cope with your weight management stressors? Yes No

PAST MEDICAL HISTORY

*Please identify which of the following **childhood illnesses** you have experienced:*

- Measles Mumps Chickenpox Obesity
- Rheumatic fever Heart murmur Asthma Tonsillectomy

Female Patients:

Number of pregnancies: _____ Age at first period: _____
 Number of live births: _____ Date of last period: _____
 Miscarriages/abortions: _____
 Obstetric complications: _____

Pregnancy #1 Year _____ Weight at start _____ at delivery _____
 Pregnancy #2 Year _____ Weight at start _____ at delivery _____
 Pregnancy #3 Year _____ Weight at start _____ at delivery _____
 Pregnancy #4 Year _____ Weight at start _____ at delivery _____

Do you presently use:

- Birth control pills Yes No List type: _____
- Estrogens Yes No List type: _____
- Other Contraceptive method: _____

Patient Name _____

Serious Illnesses:

Have you had:

- Hepatitis Blood Transfusion AIDS/HIV Exposure Cancer
- Colitis Kidney Disease Bleeding Abnormality type _____
- Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood not listed previously .

Major Illness	Date	Treatment

Major Surgery	Date

Allergies:

Allergies to any medications? Yes No If Yes, please list medication and reaction:

Allergic to: **Surgical tape?** Yes No **Latex?** Yes No **Iodine?** Yes No

Other Allergies: _____

Medications/Vitamins:

Medication	Dose and Frequency

Do you use tobacco? Yes No

Are you willing to quit? Yes No

Do you use alcohol? Yes No Frequency: _____

Office Use: Tobacco Cessation Consult

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of Death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- Obesity
- Diabetes
- High Blood Pressure
- Heart Disease
- High Blood Cholesterol
- Lung Disease, Asthma or Emphysema
- Kidney Disease
- Bleeding Tendency or Blood Disorder
- Breast Cancer
- Colon Cancer

EXERCISE WEIGHT LOSS ATTEMPTS

Program	Year	Months	Pounds Lost	Pounds Regained	Cost
Health Club					
Walking					
Jogging					
Bicycling					
Swimming					
Aerobics					
Home Equipment					
Trainer					
Other					

Exercise Habits:

How would you describe yourself (or your activity level)?

- Sedentary
- Minimally Active
- Moderately Active
- Very Active

Exercise Frequently? _____ times/week

What types of exercise do you engage in? What duration? _____

How many hours of TV do you watch per day? _____

Patient Name _____

Each of us has developed connections to food over our lifetime based upon culture, tradition and family patterns. When you think back over your life, what role has food played for you? _____

After you've been successful with weight loss, what role do you think food will play in your life?

Personal Physicians:

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist/Psychologist	_____	_____	_____
Endocrinologist	_____	_____	_____
Other	_____	_____	_____

I verify all information contained in this document to be true and factual to the best of my knowledge.

Signature

Date

Initial Patient Questionnaire reviewed by:

Signature

Date

