PATIENT MEDICAL HISTORY

Name_____Age_____Date of Birth_____

Street Address_____

CITY STATE ZIP

Phone # (Home)_____(Work)_____(Cell)_____

Email Address_____Employer_____

Emergency Contact_____Relationship_____Phone#_____

Please circle or list how you heard about our office – Referral, Google. Facebook, Sign, Newspaper, Other_____

Height _____ Weight_____ Desired Weight Goal _____

Why are you seeking weight loss at this time? _____

What was your highest adult weight and when? _____ What was your lowest adult weight and when? _____

What is your usual body weight range? _____ Reason/s for your weight gain_____

Indicate your childhood weight status: □ Under □ Average □Over

Which statement(s) best describes why you think you are overweight?
□ I eat normal amounts of foods but have an abnormal metabolism
□ I eat larger than normal amounts of healthy foods
□ I eat larger than normal amounts of healthy foods as well as sweets and snacks
□ I tend to eat a good amount of sweets and high calorie snacks
□ I am a compulsive eater
□ Other: _____

Please indicate the following methods of weight loss you have attempted. You may indicate pounds lost and length of time on program

Commercial Diets
□ Weight Watchers
□ Jenny Craig
□ Overeaters Anon
□ TOPS
□ Nutrisystem
□ Other_____

Prescription Meds
□ Redux (dexfenfluramine)
□ Pondimin (fenfluramine)
□ Fen/Phen
□ Phentermine/Fastin/Adipex
□ Meridia
□ Xenical/Alli
□

Liquid Diets
□ Optifast
□ HMR
□ Slimfast
□
Other

Popular
□ Atkins
□ Pritikin
□ Southbeach
□ Mac Dougal
□ Self Initiated

Medical and Health Care Treatments
☐ Previous Gastric Surgery
☐ Jaw Wiring
☐ Other Surgery
☐ Acupuncture
☐ Hypnosis
☐ Other

How many times a day do you eat? 1 2 3 4 5 6 7
Indicate which meals/snacks you typically eat: □ Breakfast □ am snack □ lunch □ pm snack □ dinner □ evening snack

MEDICAL HISTORY Mark (C) for current problem. ***Check (x) and indicate age when you had any of the following symptoms or diseases.***

( )Decreased hearing
( )Ringing in ear
( )Ear infections(frequent)
( )Dizzy spells ( )Fainting spells
( )Failing vision ( )Eye Pain
( )Double or blurred vision
( )Nose bleeds (recurrent)
( )Sinus trouble
( )Sore throats (frequent)
( )Hoarseness (prolonged)
( )Hayfever/Allergies
( )Bronchitis/Chronic cough
( )Asthma/Wheezing
( )Shortness of breath
( )on exertion ( )lying flat
( )Chest pain ( )Palpitations
( )Congestive Heart Failure
( )High blood pressure
( )Heart murmur
( )Irregular pulse
( )Swollen ankles
( ) Phlebitis ( )Varicose veins
( )Loss of appetite (recent)
( )Leg Pain (when walking)
( )Heartburn ( )Peptic ulcer
( )Persistent nausea/Vomiting
( )Abdominal pain (chronic)
( )Gall bladder trouble
( )Jaundice/Hepatitis
( )Lyme ( )CFS
( )Diarrhea ( )Constipation

( )Diverticulosis ( )IBS
( )Ulcerative Colitis ( ) IBD
( )Celiac Disease ( )Crohn's
( )Bloody/tarry stools
( )Hemorrhoids ( ) Hernia
( )Urinary Tract Infections (frequent)
( )Blood in urine ( )Kidney stones
( ) Urination (overnight >than twice)
( )Painful ( ) Incontinence/Loss of control
( )Decrease in force/flow
( )Venereal disease ( ) Urethral discharge
( )Weight loss (recent) ( )Gain (recent)
( )Anemia ( )Bruise easily
( )Cancer (describe)_____
( )Diabetes
( )Thyroid Disease (describe)_____
( )Sleeping difficulty ( )Sleep Apnea
( )Seizures ( ) MS
( )Stroke
( )Tremors/hands shaking
( )Numbness/tingling sensations
( )Headaches (frequent)
( )Fibromyalgia ( ) SLE
( )Rheumatoid Arthritis ( ) Osteoarthritis
( )Back Pain ( ) Neck pain
( )Bone Fracture/ joint injury
( )Gout ( )Osteoporosis
( )Foot pain ( )Cold numb feet
( )Rashes ( )Hives
( )Psoriasis ( )Eczema
( )Concentration difficulty ( )Brain Fog
( )Alzeheimer's ( ) Parkinson's

( )Depression ( ) Nervousness ( )Anxiety
( )Agitation ( )Memory loss
( )Moodiness ( )Suicidal thoughts
( )Phobias ( )Mental illness
( )Feelings of hopelessness ( )Worthlessness
( )Rheumatic Fever ( )Scarlet Fever
( )Chicken Pox ( )Polio ( )Mumps
( )Measles ( )German Measles ( ) Mono
( )Tuberculosis ( )Herpes I ( )Herpes II
( )Alcohol ____oz per week
( )Coffee/tea _____cups per day
( )Smoking ____cig/day ___#years ___year quit____

FEMALES – Please complete
Menopause ( ) # Yrs. ___
Menstrual flow
( ) Regular ( )Irregular ( ) Pain/Cramps
____Days of flow _____Length of cycle
Date of 1st day of last period_____
( )Pain/bleeding during or after sex
Pregnancies (number of)_____Pregnancies
_____Live births_____Abortions_____Miscarriages
Birth Control method_____
Birth control pill name_____
Date of last PAP test_____
( )Normal ( )Abnormal
Date of last Mammogram
( )Normal ( )Abnormal
Notes_____
_____

Patient's Silgnature_____Date_____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I **Please list your 5 major health concerns in order of importance: Please circle on the scale of 1-10, how committed are you to correcting each concern with "10" being the most committed.**

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

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating Heartburn	0	1	2	3
when lying down or bending forward Temporary	0	1	2	3
relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3

Category VI (continued)				
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____ Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? _____ How many times do you eat fish per week? _____

How many times do you eat out per week? _____ How many times do you work out per week? _____

How many times do you eat raw nuts or seeds per week? _____ _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____

Medications

Name: _____ **Date:** _____

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	**PRESCRIBED FOR:**	**HOW LONG**

Please list all drugs taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	**PRESCRIBED FOR:**	**HOW LONG**

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking, how long you have taken, and for which condition.

VITAMIN/HOW MUCH	**FOR:**	**HOW LONG**

Are you allergic to any drugs/medications (please list)? _____

Consent for Use or Disclosures of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (164.520). We reserve the right to change our privacy practices as described in that notice. If we change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your Consent Policy and agree to the terms of this policy. I am also acknowledging I have received a copy of this notice.

_____	_____
Printed Name	Authorized Provider Representative
_____	_____
Signature	Date

Appointment Reminders and Health Care Authorization

Your doctor and members of the practice staff may need to use your name, address, phone number, and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to us any anytime; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclosed based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time.(164.524).

This notice is effective as of _____and will expires seven (7) years after the date on which you last received services from us.

I authorize you to use or disclosed my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

_____	_____
Patient name printed	Date
_____	_____
Patient Signature	Authorized provider representative
_____	_____
Personal representative name printed	Personal representative signature

Description of personal representative's authority to act for the patient