PATIENT PROFILE
PERSONAL INFORMATION

Date_____ Date I attended information seminar_____

Last Name _____First Name_____MI_____

Date of Birth_____SS#_____

Home Address_____Apt#_____

City_____State_____Zip Code_____

Telephone: Home(_____)_____Work(_____)_____

Cell (_____)_____

E-Mail Address_____

Gender: Male ( ) Female ( ) **Height**: _____ft _____ins. **Weight**_____

How many years have you been at your present weight? _____

Greatest single Weight Loss _____Lbs Weight Loss Was sustained for _____months

Ethnic Group:

American Indian ( ) Hispanic ( ) Other____

African American ( ) Caucasian ( ) Asian ( )

Preferred Language:

English ( ) Spanish ( ) Other:_____

CONTACT PERSON

This information is vital to us if we need to contact you urgently.
Occasionally people move or have new phone numbers and do not update our office.

Next of Kin (NOT LIVING WITH YOU)

Name_____Relationship_____

Address_____

_____

_____

Telephone: Home(_____)_____Work (_____)_____

INSURANCE

Insurance Company:_____Policy #_____

HMO_____ PPO_____ POS_____ Other_____

Name of Insured _____

Relationship to Insured:_____Date of Birth of Insured:_____

SS# of Insured_____Insured ID#_____

REFERRAL INFORMATION

How did you hear about us? Check all that apply.

Physician ( ) Other Patient ( ) Newspaper ( ) Magazine ( )
Yellow Pages ( ) Television ( ) Our Web Site ( )
Internet Chat Room/ e-group_____Other_____

REFERING DOCTOR:

Name of Physician_____ Date of Referral_____

Address_____

City_____State_____Zip_____

CURRENT PHYSICIANS ROSTER:

Primary Care Physician:

Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Cardiologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Psychologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Psychiatrist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Pulmonologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Endocrinologist: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

Orthopedic Surgeon: Name_____

Address_____

_____state_____zip_____

Telephone: (___)_____Fax(____)_____

DETAILED DIET HISTORY

Please check all diet's you have tried and note the estimated dates of treatment

Acupuncture	( )_____	Duke University Programs	( )_____
American heart Association	( )_____	Inpatient Psychiatric Programs	( )_____
Weight Watchers	( )_____	Outpatient psychiatric Programs	( )_____
Nutrisystem	( )_____	Ionamin	( )_____
Pritikin	( )_____	Redux	( )_____
Scarsdale	( )_____	Phenteramine/ Fenfluramine	( )_____
Diet center	( )_____	fastin	( )_____
Jenny Craig	( )_____	Zenical	( )_____
Dexatrim	( )_____	Herbal diet	( )_____
Grapefruit diet	( )_____	Teeth wiring	( )_____
Rice	( )_____	Tops	( )_____
Atkins	( )_____	Calorie Counting	( )_____
Slim Fast	( )_____	Richard Simmons	( )_____
O.A.	( )_____	Exercise	( )_____
Hypnosis	( )_____	Radar Institute	( )_____
Low Fat	( )_____	Meridian	( )_____
Cabbage Diet	( )_____	Optifast	( )_____
Structure House	( )_____	Carefast	( )_____

PERSONAL MEDICAL HISTORY

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.	*Are you currently being treated for it? Check if yes*	*Are you currently Taking medication for it? Check if yes*

ENDOCRINOLOGY

Diabetes ( ) ( ) ( )

If you have been diagnosed with or treated for diabetes. Please complete the following section

Juvenile Onset ( ) Adult Onset ( )

Current form of Control: Check all that apply.

Diet Control ONLY ( )
Oral Hypoglycemics ( )
Insulin ( )

Hypothyroid ( ) ( ) ( )
Hyperthyroid ( ) ( ) ( )
Goiter ( ) ( ) ( )
Graves Disease ( ) ( ) ( )

Cardiovascular

High Blood Pressure ( ) ( ) ( )
Angina ( ) ( ) ( )
Pulmonary Hypertension ( ) ( ) ( )
Chest Pain with effort ( ) ( ) ( )
High Cholesterol ( ) ( ) ( )
High Blood Fats (Lipids) ( ) ( ) ( )
Irregular Heart Beat ( ) ( ) ( )
Heart Palpitation ( ) ( ) ( )
Congestive Heart Failure ( ) ( ) ( )
Leg Ulcers ( ) ( ) ( )
Varicose Veins ( ) ( ) ( )
Ankle Swelling ( ) ( ) ( )

Gastrointestinal

GERD ( ) ( ) ( )

How often do you have reflux during the day?

Many times per day ( ) Everyday ( ) Most days ( )
Most weeks ( ) occasionally ( )

Do you suffer from Heart Burn/ Indigestion during the night? If so how often?

Many times per night ( ) Everyday ( ) Most days ( )
Most weeks ( ) occasionally ( )

Does fluid or food reflux in the mouth?

Yes ( ) No ( )

Do you vomit with reflux?

Yes ( ) No ( )

Stomach Ulcers ( ) ( ) ( )
Duodenal Ulcers ( ) ( ) ( )
Constipation ( ) ( ) ( )

Number of Bowel Movements_____
Number per week_____
Days between Bowel Movements_____

Vomiting ( ) ( ) ( )

Everyday ( ) Most Days ( ) Most Weeks ( )
Occasionally ( ) If everyday how many times per day_____

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.		*Are you currently being treated for it? Check if yes*		*Are you currently taking medication for it? Check if yes*
Diarrhea	( )		( )		( )
Everyday	( )	Most Days	( )	Most Weeks	( )
Occasionally	( )	If everyday how many times per day_____			
Gallbladder Disease	( )		( )		( )
Gall Stones	( )		( )		( )
Inflammation/ infection	( )		( )		( )
Genito-urinary	( )		( )		( )
Urinary Frequency (Over 6x per day)	( )		( )		( )
Recurrent Urinary Tract Infection	( )		( )		( )
Kidney Stones	( )		( )		( )
Kidney Disease	( )		( )		( )
Renal Failure	( )		( )		( )
Gout	( )		( )		( )
Stress Incontinence (Leaking of Urine)	( )		( )		( )
Everyday	( )	Most Days	( )	Most Weeks	( )
Occasionally	( )	If everyday how many times per day_____			

Respiratory

Sleep Apnea: ( ) ( ) ( )

Are you currently on CPAP? No ( ) Yes ( )

If yes what are the settings? _____

Are you currently on BIPAP? No ( ) Yes ( )

If yes what are the settings? _____

Clinical symptoms of Sleep Apnea:

Do you have any of the following symptoms: (please check all that apply)

Snorting or Gasping	( )
Loud Snoring	( )
Struggle for a breath or Breathing stops	( )
Breathing chokes you	( )
Frequent awakening	( )
Tossing, Turning or thrashing	( )
Difficulty falling asleep	( )
Morning headaches	( )
Night sweats	( )
More than three pillows used under head	( )
Falling asleep when at work or school	( )
Excessive sleepiness during the day	( )
Awaken feeling paralyzed, unable to move for short periods	( )

How well rested do you feel after a full nights sleep?

Not at All ( ) Somewhat ( ) Well Rested ( )

Do You Feel Comfortable Sleeping in an upright position?

YES ( ) NO ( )

Shortness of Breath	( )		( )	( )
Activity	( )		( )	( )
Emphysema	( )		( )	( )
Chronic Cough	( )		( )	( )
Wheezing	( )		( )	( )

	Have you been diagnosed with, Or do you suffer from each of the following: check if yes.	*Are you currently being treated for it? Check if yes*	*Are you currently taking medication for it? Check if yes*
Asthma	( )	( )	( )
As a child?	( )		
As an adult?	( )		

Musculo- Sketal

Fibromyalgia	( )	( )	( )
Rheumatoid Arthritis	( )	( )	( )
Lupus	( )	( )	( )
Osteoarthritis	( )	( )	( )
Arthritis	( )	( )	( )
Ankle Pain	( )	( )	( )
Back Pain	( )	( )	( )
Knee Pain	( )	( )	( )
Plantar Fascitis	( )	( )	( )
Heel Pain	( )	( )	( )

OB/GYN

Irregular periods	( )	( )	( )
Excessively Heavy Periods	( )	( )	( )
Excessively Painful Periods	( )	( )	( )
Difficulty in Conceiving	( )	( )	( )
Infertility			
With or without treatment	( )	( )	( )
Excess Body Hair or Acne	( )	( )	( )

Head and Neck

Glaucoma	( )	( )	( )
Cataracts	( )	( )	( )
Hearing Loss	( )	( )	( )
Vertigo	( )	( )	( )
Tinnitis	( )	( )	( )
Migraine Headaches	( )	( )	( )

NEUROLOGICAL

Numbess/ Tingling-hands	( )	( )	( )
Feet	( )	( )	( )
Front or side of thigh	( )	( )	( )
Seizures	( )	( )	( )
Weakness- Hand	( )	( )	( )
Weakness- Feet	( )	( )	( )
Epilepsy	( )	( )	( )
Pseudotumor Cerebri	( )	( )	( )

SKIN

Dermatitis	( )	( )	( )
Urticaria	( )	( )	( )
Rashes	( )	( )	( )
Open Sores	( )	( )	( )

	Have you been diagnosed with, Or do you suffer from each of the following:	*Are you currently being treated for it?*	*Are you currently Taking medication for it?*

HEMATOLOGY

Anemia ( ) ( ) ( )

Heparin Exposure

When where you exposed?_____

Why?_____

Coumidin Use

When did you use?_____

Why?_____

Iron Supplemensts

When did you use?_____

Why?_____

	Have you been diagnosed with, Or do you suffer from each of the following: Check if yes	*Are you currently being treated for it? Check if yes*	*Are you currently Taking medication for it? Check if yes*

PSYCHOLOGICAL

Depression	( )	( )	( )
Bi-Polar Disorder	( )	( )	( )
Anxiety	( )	( )	( )
Schizophrenia	( )	( )	( )
Anorexia	( )	( )	( )
Bulimia	( )	( )	( )
Suicide Attempt	( )	( )	( )

INFECTIOUS DISEASES

HIV Positive	( )	( )	( )
Staph Infection	( )	( )	( )
Liver Disease	( )	( )	( )
Hepatitis A	( )	( )	( )
Hepatitis B	( )	( )	( )
Hepatitis C	( )	( )	( )

PAST SURGICAL HISTORY

Please indicate with a check any type of surgeries you have had and indicate the year of the surgery

TYPE OF SURGERY		YEAR	TYPE OF SURGERY		YEAR
Adenoidectomy	( )	_____	Hemorrhoidectomy	( )	_____
Angioplasty	( )	_____	Gastric Bypass	( )	_____
Ankle Surgery	( )	_____	Hernia Repair	( )	_____
Appendectomy	( )	_____	Hysterectomy	( )	_____
Back Surgery	( )	_____	Knee Surgery	( )	_____
Breast Augmentation	( )	_____	Lap Band	( )	_____
Breast Reduction	( )	_____	Liposuction	( )	_____
Breast Biopsy	( )	_____	Lumbar Laminectomy	( )	_____
Carpal Tunnel Surgery	( )	_____	Mastectomy	( )	_____
Cesarean Section	( )	_____	Oral Surgery	( )	_____
Cholecystectomy (Gall Bladder)	( )	_____	Ovarian Cystectomy	( )	_____
Coronary Bypass	( )	_____	Panniculectomy	( )	_____
D&C	( )	_____	Pilonidal Cystectomy	( )	_____
Lasik	( )	_____	Tonsillectomy	( )	_____
Prostate Surgery	( )	_____	Tubal Ligation	( )	_____
VBG	( )	_____	Wisdom Teeth	( )	_____

Any problems with anesthesia?
Yes ( )No ( )
If yes, please describe_____
_____

Have you ever had a Hernia?
Yes ( ) No ( )
If yes, what type?
Umbilical ( ) Hiatal ( )
Inguinal "groin" ( ) Ventral ( )

Do you currently have a Hernia?
Yes ( ) No ( )
If yes, what type?
Umbilical ( ) Hiatal ( )
Inguinal "groin" ( ) Ventral ( )

Will you accept a Blood Transfusion if needed?
Yes ( ) No ( ) If no, reason_____

Have you had a previous blood Transfusion?
Yes ( ) No ( )
If so, Date and Reason_____

Please list any current medical conditions or concerns not covered above
_____
_____
_____
_____

Details of any other hospitalizations for medical problems
_____
_____
_____
_____

ALLERGIES

DRUG			INDICATE REACTION
No Know Drug Allergies	( )	→	_____
Aspirin	( )	→	_____
Codeine	( )	→	_____
Demerol	( )	→	_____
Erythromycin	( )	→	_____
Iodine	( )	→	_____
Keflex	( )	→	_____
Morphine	( )	→	_____
Penicillin	( )	→	_____
Sulfa	( )	→	_____
Tetracycline	( )	→	_____
Vicodin	( )	→	_____
Other	( )	→	_____

Latex allergy screening questionnaire

Do you have an allergy to any latex products?
Yes ( ) No ( )

Have you experienced local swelling, itching or dermatitis associated to contact with latex?
Yes ( ) No ( )

Do you have a history of wheel or blister formation on contact with latex products?
Yes ( ) No ( )

Have you had an allergic reaction to tape?
Yes ( ) No ( )

Does your occupation involve exposure to NRL? “Natural Rubber Latex”
Yes ( ) No ( )

Food allergy screening questionnaire

Do you have any food allergies?
Yes ( ) No ( )

Are you allergic to:

Kiwi	Yes ( ) No ( )
Banana	Yes ( ) No ( )
Avocado	Yes ( ) No ( )
Chestnuts	Yes ( ) No ( )

MEDICATIONS

Name of Medication	mg/units	# of times taken daily	Reason for Medication

Please list in detail all Medications that you have used in the last 12 months. Please include dietary supplements, crèmes, eye drops, etc.

Name of Medication	mg/units	# of times taken daily	Reason for Medication

PERSONAL MEDICAL INFORMATION

Have you ever been diagnosed with Cancer?

Yes ( ) No ( )

If yes, check all that apply

( ) Breast	( ) Endomitrial	( ) Prostate	( ) Colon
( ) Thyroid	( ) Skin	( ) Blood	( ) Other _____

Year Diagnosed _____ Cancer Free for_____Years

Treatment, check all that apply

( ) surgery	( ) Chemotherapy	( ) Radiation	( ) Medication

Do you have regular dental check ups?
Yes ( ) No ( )

Have you had previous dental surgery?
Yes ( ) No ( )

Do you wear Dentures?
Yes ( ) No ( )
If yes, ( ) Upper ( ) Lower

Do you wear glasses?
Yes ( ) No ( )

Do you wear contacts?
Yes ( ) No ( )

Do you have missing teeth?
Yes ( ) No ( )
If yes, how many? _____

Have you ever had an:

EKG
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Stress Test
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Echocardiogram
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

Cardiac Catheterization
Yes ( ) No ( )
If yes were the results:
( ) Normal ( ) Abnormal ( ) Further Testing Required

SOCIAL PROFILE

Marital Status:
Never Married ( ) Married ( )
Divorced ( ) Widowed ( ) Separated ( )
Spouses Name_____

Family structure:
Do you have any children?
Yes ( ) No ( ) **If yes, how many? _____**

How many children/ grandchildren in each of the following age groups do you have living with you?
Include nieces, nephews or other dependents

_____ 0-2 years old _____8-12 years old _____18-25 years old
_____ 2-8 years old _____ 12-18 years old _____over 25 years old

Do you have a person for support?
Yes ( ) No ( )
Do they live with you?
Yes ( ) No ( )

Combined Household Income:
( ) Less than $20,000 ( ) $40,000-59,999 ( ) $80,000-$99,999
( ) $20,000-$39,999 ( ) $60,000-79,999 ( ) $100,000 or more

Current employment
Are you currently employed?
Yes ( ) No ( )
Occupation_____

Employer_____

Approximate Income
( ) Less than $20,000 ( ) $40,000-59,999 ( ) $80,000-$99,999
( ) $20,000-$39,999 ( ) $60,000-79,999 ( ) $100,000 or more

If employed, please state what level of activity your job involves:
( ) Little ( ) moderately active ( ) Very active
Do you enjoy your work?
Yes ( ) No ( )

If you are unemployed, for how long? _____
What is the reason? (Check one)
( ) Physically unable to work ( ) emotionally unable to work ( ) Lack of skills
( ) Lack of available jobs in the field ( ) Appearance inappropriate for position sought
Are you currently disabled or on disability?
Yes ( ) No ( )
If so, for how long? _____

Education

Please check the level of highest completion.
( ) 8th grade ( ) High school graduate ( ) College graduate
( ) Some high school ( ) some college ( ) any post graduate work

SOCIAL DATA

Do you drink coffee? **Do you smoke cigarettes?**

Yes ( ) No ( ) How many cups per day_____ Yes ( ) No ( ) If yes, how long_____

Do you smoke cigars? **How long ago did you stop smoking?**

Yes ( ) No ( ) how many per day? _____ _____years _____months

Do you drink alcohol?

Yes ( ) No ( )

If yes, how often?

( ) Everyday ( ) Most Days ( ) Most Weeks ( ) Most Months ( ) Rarely

If yes, when drinking do you tend to binge to excess?

Yes ( ) No ( )

Do you have a history of drug or alcohol addiction?

Yes ( ) No ( )

If yes, how long have you been alcohol or drug free?

_____Months

What treatment did you receive? Check all that apply

( ) Residential treatment ( ) Counseling ( ) Support groups such as AA

SPIRITUAL CARE

Please share with us your religious preference._____

Are there any specific religious or spiritual needs we should be aware of that would directly affect your care?_____

_____

Do you have someone who will directly provide you with spiritual support through this process?

Yes ( ) No ( )

May we contact them if necessary?

Name:_____ Number: (____)_____

Our interdisciplinary team includes the service of a professional Chaplain, who is available at no charge to you and your family, and is part of the office staff.

( ) Yes, I would like to see the Chaplain

- ( ) During the assessment process
- ( ) Before Surgery
- ( ) In the Hospital
- ( ) After the surgery for support
- ( ) As a pastoral counselor to assist with necessary life-style changes

( ) No, I will not be requiring the services of the Chaplain, but understand that he is available, should I change my mind.

In the event that you are unable to make healthcare or end of life decisions for yourself, an Advance Directive for Healthcare Decisions affords you the opportunity to legally state in advance your wishes. An Advance Directive also allows you to name a Healthcare Surrogate to voice your decisions or concerns.

Have you completed an Advance Directive for Healthcare Decisions? ( ) Yes ( ) No

If yes, would you please bring a copy with you for our files. You will also be asked this question at the hospital and it would benefit you to insure they have a copy.

FAMILY MEDICAL HISTORY

FATHER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your father have a history of…
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

MOTHER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your mother have a history of…
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

SISTER:
Please check one:
( ) Living ( ) Deceased If deceased:Age_____
Cause of Death:
( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes
( ) Heart Disease/ Stroke/ Heart Attack
Did your sister have a history of…
Check all that apply:
( ) History of Obesity
( ) Heart Disease
( ) Hypertension
( ) Diabetes
( ) History of Cancer
Type:
( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon
( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

BROTHER:

Please check one:

( ) Living ( ) Deceased If deceased:Age_____

Cause of Death:

( ) Cancer ( ) Accident ( ) Age related ( ) Diabetes

( ) Heart Disease/ Stroke/ Heart Attack

Did your brother have a history of…

Check all that apply:

( ) History of Obesity

( ) Heart Disease

( ) Hypertension

( ) Diabetes

( ) History of Cancer

Type:

( ) Breast ( ) Endomitrial ( ) Prostate ( ) Colon

( ) Thyroid ( ) Skin ( ) Blood ( ) Other _____

I attest to the fact all the information submitted by me in this document are true and correct to the best of my knowledge and belief.

_____ _____

Patient's Signature Date