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)

Symptom	
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?
Yes ( ) No ( ) How many cups per day_________

Do you smoke cigarettes?
Yes ( ) No ( ) If yes, how long__________

Do you smoke cigars?
Yes ( ) No ( ) how many per day? ___________

How long ago did you stop smoking?
__________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