**PATIENT INFORMATION** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been a patient here before? Yes \_\_\_\_\_\_ (Date) \_\_\_\_\_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI: \_\_\_\_\_\_\_\_\_\_LAST NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU HAVE A PO BOX FOR MAILING PLEASE LIST ADDRESS:**

PO BOX # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the best telephone number to contact you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we leave a message at the above number? Yes or NO**

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FIRST MIDDLE LAST

 Who may we contact in case of emergency?

 FULL NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your regular family doctor? Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRAL INFORMATION**

*HOW DID YOU HEAR ABOUT THE STEELMAN CLINIC? Please check one of the following:*

** RELATIVE /FRIEND/CO-WORKER…. WHOM MAY WE THANK FOR REFERRING YOU? PLEASE PRINT**

**REFERRED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**­­­­­­­­­­

 TV  RADIO  PRINT  SIGNAGE  INTERNET  SOCIAL MEDIA

 OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have reviewed, or have had access to, the privacy policy for Steelman Clinic**

**SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WEIGHT HISTORY**

What has been your heaviest weight? \_\_\_\_\_lbs. What is the least you have ever weighed as an adult? \_\_\_\_\_\_\_lbs.

1. Your present weight: Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Describe your present weight (check one) Obese \_\_\_\_ Very Overweight\_\_\_\_ Slightly Overweight *\_\_\_\_*
3. How long have you been overweight? a. Less than one year b. 1-5 years c. Five or more years
4. When did your weight problem begin?

a. As a child b. As a teenager c. Adulthood/After Marriage d. After Childbirth e: Other \_\_

1. Which other family members are obese?

a. Mother b. Father c. Siblings d. Children e. Spouse

1. Do you feel you can lose weight easily through your own efforts? Yes / No
2. Appetite suppressant medications are optional in our programs. Do you prefer to use suppressants? Yes /No
3. Present or past history of eating disorders? Yes / No
4. Anorexia- fear of weight gain leading to malnutrition and usually excessive weight loss \_\_\_ Yes
5. Bulimia- overeating followed by vomiting, laxative/diuretic abuse and/or excessive exercise \_\_\_ Yes
6. Binge Eating Disorder- consuming a large quantity of food in a short period of time \_\_\_ Yes
7. Night Eating Disorder- eating very late at night, waking up in the middle of the night to eat. \_\_\_ Yes

**DIETARY HISTORY**

Approximate age you first seriously started dieting: \_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Please identify the diets and diet programs you have tried, if any:** |  |  |
| **Program** | **YES** | **NO** | **Date** | **Duration** | **Program** | **YES** | **NO** | **Date** | **Duration** |
| **Jenny Craig** |  |  |  |  | **Atkins Diet** |  |  |  |  |
| **Weight Watchers** |  |  |  |  | **Metabolife** |  |  |  |  |
| **Nutri-Systems** |  |  |  |  | **MediFast** |  |  |  |  |
| **Behavior Modification** |  |  |  |  | **Intestinal Bypass** |  |  |  |  |
| **Supervised Diet** |  |  |  |  | **Hypnosis** |  |  |  |  |
| **Your own diet** |  |  |  |  | **Stomach Stapling** |  |  |  |  |
| **Starvation/Liquid Diet** |  |  |  |  | **Gastric Bypass** |  |  |  |  |
| **HCG Shots** |  |  |  |  | **Other:** |  |  |  |  |
| **Appetite Suppressants** |  |  |  |  | **Other:** |  |  |  |  |
| **OptiFast** |  |  |  |  | **Other:** |  |  |  |  |

**Eating Habits**: \_\_\_ Sweets \_\_\_ Salty snacks \_\_\_ Portion Control \_\_\_ Skipping meals

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

Marital Status: \_\_Single \_\_Engaged \_\_ Married \_\_\_Partner \_\_\_Separated \_\_\_Divorced \_\_Widowed/Widower

 Do you use tobacco? \_\_\_ Never Smoked \_\_\_ Current Smoker

Do you use alcohol? \_\_\_Yes \_\_No If yes, how often: \_\_\_\_\_\_\_\_\_\_\_ Type of alcohol: \_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently use recreational drugs? \_\_\_Yes \_\_\_No

If no, have you ever used recreational drugs? \_\_\_Yes \_\_\_No

Have you ever been treated for narcotic/ alcohol dependency? \_\_\_Yes \_\_\_No

**MEDICAL HISTORY**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Condition** | **Current** | **Past** | **Medical Condition** | **Current** | **Past** |
| **AIDS** |  |  | **Hemorrhoids** |  |  |
| **Alcohol Abuse** |  |  | **Hepatitis A** |  |  |
| **Allergies (Seasonal)** |  |  | **Hepatitis B** |  |  |
| **Angina** |  |  | **Hepatitis C** |  |  |
| **Anxiety** |  |  | **Hernia** |  |  |
| **Arthritis** |  |  | **High Blood Pressure** |  |  |
| **Asthma** |  |  | **High Cholesterol** |  |  |
| **Back Pain** |  |  | **High Triglycerides** |  |  |
| **Bleeding Abnormality** |  |  | **Incontinence** |  |  |
| **Blood Clot** |  |  | **Infertility** |  |  |
| **Bronchitis** |  |  | **Irregular Menses** |  |  |
| **Cancer** |  |  | **Irritable Bowel** |  |  |
| **Colitis** |  |  | **Kidney Disease** |  |  |
| **Crohn’s Disease** |  |  | **Kidney Stones** |  |  |
| **Deep Vein Thrombosis** |  |  | **Liver Disease** |  |  |
| **Depression** |  |  | **Lung Disease** |  |  |
| **Diabetes I / II** |  |  | **Mental Illness** |  |  |
| **Diverticulitis** |  |  | **MI/ Heart Attack** |  |  |
| **Emphysema** |  |  | **Neuropathy** |  |  |
| **Endometriosis** |  |  | **Planter Fasciitis** |  |  |
| **Epilepsy** |  |  | **Polycystic Ovarian Syndrome** |  |  |
| **Fatty Liver** |  |  | **Pulmonary Embolus** |  |  |
| **Gallbladder Disease** |  |  | **Rheumatic Fever** |  |  |
| **Gestational Diabetes** |  |  | **Shortness of Breath** |  |  |
| **Gout** |  |  | **Sleep Apnea** |  |  |
| **Heart Disease** |  |  | **Stomach Ulcer** |  |  |
| **Heart Palpitations** |  |  | **Stroke** |  |  |
| **Heart Murmur** |  |  | **Thyroid Problems** |  |  |
| **Other:** |  |  | **Other:** |  |  |

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SURGICAL HISTORY**

|  |  |
| --- | --- |
| **Type of Surgery** | **Date of Surgery** |
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**FAMILY HISTORY**

Additional Family History: (check the ones that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease /Problem** | **Mother** | **Father**  | **Sibling** |
| **Alcoholism** |  |  |  |
| **Cancer** |  |  |  |
| **Diabetes** |  |  |  |
| **Heart Disease** |  |  |  |
| **Hypertension** |  |  |  |
| **Sleep Apnea** |  |  |  |
| **Stroke** |  |  |  |
| **Other:** |  |  |  |
| **Other:** |  |  |  |
| **Other:** |  |  |  |
|  |  |  |  |

**MEDICATION ALLERGIES**

**□ Check here if you have no known drug allergies**

|  |  |
| --- | --- |
| **Medication** | **Type of reaction** |
|  |  |
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**Are you allergic to Latex? \_\_\_Yes \_\_\_No**

**Are you allergic to Iodine? \_\_\_Yes \_\_\_No**

 **Are you allergic to surgical tape? \_\_\_Yes \_\_\_No**

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATIONS- PRESCRIPTION, HERBAL, OVER THE COUNTER**

**How many times per week do you take Ibuprofen or Aspirin? \_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Medication Name**  | **Dosage** |
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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill out the following questions with honest answers:**

**What is your typical breakfast? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your typical lunch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your typical dinner? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What is your “go to” snack? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink soda, diet soda, or energy drinks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If yes, how many per day? \_\_\_\_\_\_**

**How many hours of sleep do you average per night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you tired during the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have an exercise routine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you cook? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you drink alcohol? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, how much per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How many meals do you eat out per week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you “crash” 1-2 hours after eating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you find yourself “starving” mid/late morning or mid/late afternoon? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you been diagnosed with auto immune disorder/disease? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If yes, which disorder/disease? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have food allergies/sensitivities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If so, what foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**When did you start gaining weight that became difficult to lose? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How likely are you to count calories or net carbohydrates every day? (Please circle below)**

**Never Not likely Maybe Likely Always**