



WEIGHT LOSS PATIENT INFORMATION RECORD

PLEASE BRING THIS COMPLETED FORM TO YOUR APPOINTMENT

Date: ___/___/___

Last Name: _____ First: _____ MI: _____

Date of Birth: ___/___/___ Sex: _____ Age: _____

Home Phone: () _____ Mobile Phone: () _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail : _____ Race _____ Ethnicity _____ Language _____

Marital Status: _____ Spouse's Name: _____

Primary Care Physician: _____ Telephone: () _____

Pharmacy Information

Pharmacy _____ Location _____

Phone _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Phone: () _____

WHAT BRINGS HERE TODAY? (Chief Complaint)

WEIGHT GAIN HISTORY (HPI)

When did you first become overweight? (your age then) _____ (year) _____

How did your weight gain start? Describe any circumstances: _____

What do you think is the cause of your weight problem? _____

Your present weight: _____ your weight goal: _____ Your height: _____

What was your highest weight? (excluding pregnancy) _____ your age then _____ # of years ago: _____

What was your lowest weight? _____ your age then _____ # of years ago: _____

Have you ever stayed the same weight for 10 years or more? Yes/ No

Have you attempted to lose weight before? _____ most lbs lost: _____ how long it took: _____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results: _____

Where and when do you do most of your overeating? _____

Please make any comments that you think might be helpful: _____

Do you exercise? ___ No ___ Yes, please specify the type of exercise, duration of exercise, and frequency of exercise: _____

When was your last menstrual period? _____

What is your current method of birth control? Pills Diaphragm IUD Tubal Ligation Hysterectomy Abstinence Other: _____

CURRENT MEDICATIONS

(Prescribed medications that you are **currently taking**)

Name of Drug	Strength	# of times taken per day	Prescribing Provider
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PAST MEDICAL HISTORY

Have you had any of the following health problems? (check all that apply)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Polycystic Ovary Syndrome (PCOS) | <input type="checkbox"/> Diabetes, Specify Type: _____ | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Angina or chest pain | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Seizure or epilepsy |
| <input type="checkbox"/> Arthritis | | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma or wheezing | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> TIA or stroke |
| <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Overweight/Obesity | |
| <input type="checkbox"/> Cancer: what type _____ | | | |

Note: If you checked yes to any of the above questions, please provide additional information: _____

When was your last physical exam? _____ When was your last pap smear? _____

Proceed to next page

ALLERGIES

Do you have any drug allergies that you are aware of? Yes No

Item	Reaction	Item	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any shellfish? Yes No

SURGICAL and HOSPITALIZATION HISTORY

Reason for Surgery/Hospitalization	Where Performed	When	Surgeon (if applicable)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

GENERAL FAMILY HISTORY

Please indicate the following regarding your family:

	Status	Year of Birth (if known)
Mother	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Father	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Paternal Grandmother [Father's Side]	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Maternal Grandmother [Mother's Side]	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Paternal Grandfather [Father's Side]	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Maternal Grandfather [Mother's Side]	<input type="checkbox"/> Alive <input type="checkbox"/> Deceased	
Are any of your siblings deceased?	<input type="checkbox"/> No <input type="checkbox"/> Yes, specify cause of death: _____	

Review the list below and use the scale below to indicate the person in your family who has had the disease or illness.

M= Mother F= Father PGM= Paternal Grandmother MGM= Maternal Grandmother
PGF= Paternal Grandfather MGF= Maternal Grandfather S= Siblings C=Children

_____ Angina or chest pain	_____ Breast Cancer	_____ Diabetes	_____ Thyroid disease
	_____ Heart attack	_____ High Blood Pressure	_____ TIA or stroke
_____ Cancer: what type	_____		
_____ Other, specify	_____		

SOCIAL HISTORY

Marital Status

___ Divorced	___ Remarried	___ Spouse Deceased
___ Engaged	___ Separated	___ Significant other Deceased
___ Married living w/spouse	___ Single	

Employment

Are you currently employed? Yes / No

What is/was your occupation? _____

Current employment status (please check all that apply):

 Employed full-time Unemployed Employed part-time Retired Student Homemaker Disability**Review of Systems**

Please mark all items that apply to you.

Constitutional Recent change in weight

Gain _____ lb.

Loss _____ lb.

Eyes/Ears/Nose/Throat Blurring Vision Glaucoma Dizziness**Cardiovascular** Heart Disease Heart Attack Stroke High Blood Pressure Chest pain Irregular heartbeat Heart murmur Ankle swelling**Respiratory** Wheezing Chronic cough Asthma Shortness of breath**Gastrointestinal** Heartburn Change in bowel habit Constipation Nausea Vomiting Diarrhea Hepatitis Ulcers Blood in Stool**Genitourinary** Kidney trouble Frequent/painful urination Blood in urine**Gynecological** Infertility Heavy periods Infrequent periods**Skin** Skin cancer Rash**Neurological** Headaches Seizures Numbness-tingling in extremity Weakness in extremity**Psychiatric** Excessive worry Depression Bipolar Disorder suicide attempt Memory loss Psychiatric hospitalization other psychiatric diagnosis**Endocrine** Thyroid trouble Tremor**Hematological** Excessive bleeding HIV positive



Policies and Procedures

Thank you for selecting Lake Norman Pain and Weight Management, PLLC for your health care needs. We are honored to be of service to you and your family. Please complete the following form Initial Below

_____ Payment for all services is due at the time services are rendered, unless prior arrangements have been made.

_____ I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

_____ I understand that our office sees patients by appointment only. I understand that if I am 15 minutes late for my appointment, it will be rescheduled for another date and/or time. I understand that I need to give 24 hours' notice to cancel or reschedule my visit.

_____ I authorize LNPWM to leave a brief message on the voicemail of my home and/or cell phone to remind me of upcoming appointments.

_____ I authorize LNPWM to leave a brief message with individuals answering my home phone or cell phone to remind me of upcoming appointments.

_____ I authorize Lake Norman Pain & Weight's Fitness & Nutrition Coach to contact me for follow up via phone. I authorize LNPWM to email information to me at my request. I understand that if the email is not sent in an encrypted manner there is a risk that it could be accessed inappropriately. I still elect to receive email communication.

Please check boxes for the types of information that you may want emailed:

Financial Information Appointment Reminder Breach Notification

Other: _____

I authorize LNPWM to release information to the following individuals:

Name of Individual	Relationship	Phone Number	Information to be Released
			<input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Other
			<input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Other
			<input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Other
			<input type="checkbox"/> Financial <input type="checkbox"/> Treatment Plans <input type="checkbox"/> Other

Patient Rights in regard to release of information:

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I ask for it; The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

I have read and understand all of the above and have agreed to the initialed statements.

_____ Patient's Signature

_____ Date

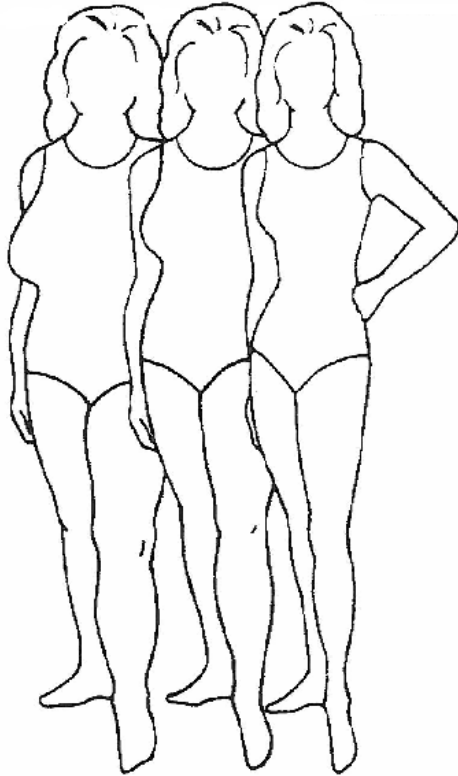
FOR INTERNAL OFFICE USE ONLY

VITAL SIGNS & MEASUREMENTS

Date: _____ **Height:** _____ **Weight:** _____ **BP:** _____ **HR** _____

Measurements Before

Neck _____
Arm _____
Ribs _____
Bust _____
Mid-Section _____
Hips _____
Lt Thigh _____



Measurements After

Neck _____
Arm _____
Ribs _____
Bust _____
Mid-Section _____
Hips _____
Lt Thigh _____

TOTAL: _____
Weight: _____
BMI: _____

TOTAL: _____ (Ch: _____)
Weight: _____ (Ch: _____)
BMI: _____
Date: _____

Plan Selected: Full hCG Mini G Appetite Suppressant

B-Complex R L Glute **Lipase** R L Glute **Shakeology Sample**

Culture Index Survey Completed Informed Consent Signed Labs Ordered

Notes

___ WLC Note Done ___ Claim Done