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, and 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)

___Breast Cancer	___Polycystic Ovary Syndrome (PCOS)	___Diabetes, Specify Type: ______________________	____Eating Disorder
___Angina or Chest pain	___Chronic cough	___Kidney Disease	___Seizure or Epilepsy
___Arthritis		___Liver Disease	___Thyroid Disease
___Asthma or Wheezing	___Heart Attack	___Peptic Ulcer	___TIA or Stroke
___Bleeding Problems	___High Blood Pressure	____Overweight/Obesity	
___Cancer: 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	_____ Alive ____Deceased	
Father	_____ Alive ____Deceased	
Paternal Grandmother [Father's Side]	_____ Alive ____Deceased	
Maternal Grandmother [Mother's Side]	_____ Alive ____Deceased	
Paternal Grandfather [Father's Side]	_____ Alive ____Deceased	
Maternal Grandfather [Mother's Side]	_____ Alive ____Deceased	
Are any of your siblings deceased?	____No ____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: 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
___Employed part-time
___Student
___Disability
___Unemployed
___Retired
___Homemaker

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
__Changes 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 may 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 10 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 Clinical staff 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
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ Other
			☐ Financial ☐ Treatment Plans ☐ 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 effect 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.

_______________________________________ _______________________________

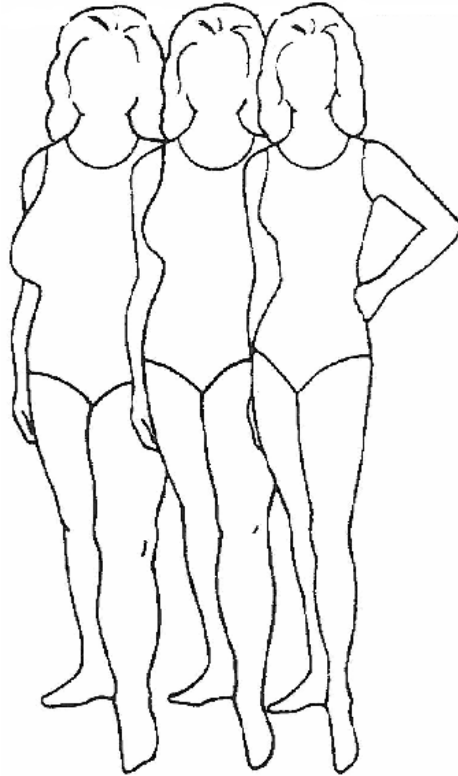
Patient's Signature Date

FOR INTERNAL OFFICE USE ONLY

VITAL SIGNS & MEASUREMENTS

Date: __________ **Height:** ________ **Date:** _____________

Measurements Before	**Measurements After**
Neck_______	**Neck**_______
Arm_______	**Arm** _______
Bust_______	**Bust**_______
Ribs _____	**Ribs** _____
Waist_____	**Waist** ____
Mid-Section ______	**Mid-Section** _____
Hips_____	**Hips** _____
Lt. Thigh________	**Lt. Thigh**__________
TOTAL: __________	**TOTAL:** _________ **(Ch: ______)**
Weight: _________	**Weight**: _________ **(Ch: ______)**
BMI: _____________	**BMI**: _____________



Plan Selected: ☐ **Appetite Suppressant** ☐ **Mini HCG** ☐ **Full HCG**

B-Complex R L Deltoid / Glute **Lipase** R L Deltoid / Glute **Combo** R L Deltoid / Glute

☐ **Informed Consent Signed** ☐ **Received Informational Packet** ☐ **Labs Ordered**

Notes

___WLC Note done _____ Claim Done