Name: _____ DOB: _____

Medical and Social History

Do you or any family member have any of the following? (Please specify: S=self, M=mother, F=Father)

___ High Blood Pressure
___ Heart Disease
___ High Cholesterol
___ Thyroid Disease
___ Low Energy
___Anxiety/Stress
___ Prostate Problems
___ Yeast Infections
___ Kidney Infections
___ Ulcers
___ Glaucoma
___ Eating Disorders (Bulimia/Anorexia)
___ Kidney Disease
___ Lactose Intolerance
___ Celiac Disease
___ Colon Problems
___ Constipation
___ Diverticulitis
___ Cramps (PMS)
___ Food Cravings
___ Sleep Apnea
___ TIA's (mini-stroke)
___ Liver Disease
___ Illicit Drug Use
___ Gout
___ Acid Reflux
___ Trouble Sleeping
___ Joint problems/ Aches
___ Bloating
___ Juvenile Diabetes
___ Pre- Diabetes
___ Diabetes
___ Depression
___ Pacemaker/ Defibrillator
____Joint Pains

Do you smoke? Yes / No If yes, how much? _____
How often? _____

Do you drink? Yes / No If yes, how much? _____
How often? _____

Marital Status: Single **Married** **Divorced** **Widowed** **Other**: _____

Are you pregnant? Yes / No

Have you had any surgeries? _____

_____

Do you take any medications (including prescriptions, over-the-counter, vitamins)?

_____ _____

_____ _____

_____ _____

Pharmacy: _____ Phone #: _____

Allergies to any medications: _____

HEALTHY OUTCOMES

ATLANTIC FAMILY PHYSICIANS
NEW PATIENT REGISTRATION
PLEASE PRINT

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work phone: _____

Date of Birth: _____ SSN#_____ Sex: _____ Marital Status: _____

Race: _____ Email Address: _____

Employer: _____

Guarantor/Spouse/Parent: _____ Relationship: _____

Address: _____ Phone #: _____

Pharmacy: _____ Phone#: _____

Do you have insurance? YES or NO (please circle)

Name of Insurance: _____

Subscriber's Name: _____ D.O.B_____ SSN#_____

PATIENT RELEASE: I, THE UNDERSIGNED, HAVE MEDICARE/INSURANCE COVERAGE AS NOTED ABOVE AN ASSIGN DIRECTLY TO ATLANTIC FAMILY PHYSICIANS, LLC, ALL MEDICAL BENEFITS. I AUTHORIZE RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANIES AND OTHER PHYSICIANS AS IS NECESSARY FOR FILING MEDICAL CLAIMS OR FOR CONSULTANTS. I AUTHORIZE PAYMENT OF MEDICAL CLAIMS TO BE PROVIDER. I DUNERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES NOT PAID BY INSURANCE I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSIONS. I UNDERSAND THAT IF I HAVE NO INSURANCE, I AM LIABLE FOR THIS ACCOUNT.

Signature : _____ Date : _____

Healthy Outcomes
MEDICAL WEIGHT LOSS

Weight Loss Profile

Dietary consultation involves a weight loss profile. Its purpose is not to establish a diagnosis, but rather to determine a patient's health status to guide his or her weight-loss plan. A patient may be advised to seek medical advice based on his or her weight loss profile.

General **Date:** _____

Name: _____ Age: _____ DOB: _____

How did you hear about our program? _____

Job/Occupation_____ Who is your PCP? _____

Email Address: _____

Do you take multivitamins? Yes or No

Do you take fish oil? Yes or No

Do you consume drinks with sugar? (EX. Soda, Juice, Tea, Coffee, ETC.) Yes or No

Are you allergic to any medicines or foods? _____

_____

Have you ever had your metabolism tested? Yes or No (By whom? _____)

Current Weight Pattern: Steady Gaining Stable Frequent Loss& Regain

Do you exercise? Yes or No If no, please state why: _____

If yes:

How many days a week: _____ How many minutes each day: _____

What is your exercise of choice? _____

What is your goal? (please circle all that apply) Weight Loss Muscle Size Fitness Flexibility Health

Please name your two favorite foods: _____

What types of food do you usually crave? _____

Do you feel hunger throughout the day? Yes or No If yes, is it: Mild, Moderate, or Severe

Do you look for food when you are sad or stressed? Yes, No, or Sometimes

Do you think that eating food gives you a lot of pleasure? Yes or No

Do you ever find yourself eating after you feel full/ satisfied? Always Often Rarely Never

Have you ever tried to lose weight before? Yes or No

If yes, please tell us what you have done that has worked, how much have you loss and how long it took: _____

_____

Why do you think your previous weight loss experience did not work for your (ex) too complicated, too much cooking involved, no maintenance plan, ETC:_____

_____

Have you had surgery for weight loss? Yes or No

What time do you usually eat: Breakfast: _____ Lunch: _____

Dinner: _____ Snacks: _____

Are you often in a rush for time? Yes or No

Do you have a lot of structure with your diet? Yes or No

How many servings of fruit do you consume each day? _____ What type of fruits do you eat? _____

_____

How many servings of vegetables do you consume each day? _____

Do you snack before bed? Yes or No

Do you snack in the middle of the night? Yes or No

Do you use meal replacements? Yes or No

How many glasses of water do you drink each day? _____

How many hours do you sleep each night? _____

Please give an example of a typical breakfast, lunch, dinner and snack.

(Please be specific, ex: 2 slices of toast with butter, 8oz O.J., 8oz coffee with 2 tablespoons of sugar and cream)

A typical breakfast: _____

_____

A typical lunch: _____

_____

A typical dinner: _____

_____

A typical dessert (only if you have dessert after most meals): _____

_____

A typical snack: _____

_____

Which one is your largest meal of the day? _____

Which meal(s) do you tend to skip? _____

Do you dine out, stop for fast food or pizza? Yes or No How often? _____

Do you want us to send progress notes to your doctor? Yes or No

What is your current height? _____ ft. _____ inches

What is your current weight? _____ lbs.

What was your highest weight? _____ lbs.

What is your goal weight? _____ lbs.

When did you begin to gain weight? _____

How long have you been overweight? _____

Please tell us the main reason(s) why you want to lose weight: _____

Any additional information you would like for us to know? _____

_____

_____

Payment Agreement:

Consultations might be covered by insurance when appropriate. Those who have insurance, but we are unable to bill their insurance for the consultations need to pay for the consultation fee before the appointment. Once a program is determined the monthly (4 weeks). By signing the following you agree to the pay HEALTHY OUTCOMES MEDICAL WEIGHT LOSS CENTER every four weeks if you are a part of the weight loss program. Payments may be made by check, cash or credit card. The cost of four week programs does not include the visit with the physicians or the lab work. The physician's visits and lab work are billed through insurance and co-pays for these visits need to be paid the day of the physicians/patient visit.

No potential dieter is to be placed on a high protein protocol with a history of or current diagnosis of the any following conditions without written consent from his/her primary care provider or specialist monitoring this patient visit.

- History of cardio-vascular events: (i.e. heart attack, stroke, aneurysm, by-pass, stent surgery, history of having cardiac arrhythmia including having a pace-maker)
- History of or current active cancer, including skin cancers
- Pregnant female (note from OB/GYN only)
- Breast feeding female
- Severe liver disease
- Diagnosis or history of congestive heart failure (CHF)
- Patients currently on Lithium therapy
- Patients with a diagnosis of Parkinson's Disease

I agree to consult with my primary care physicians to guarantee the safety of the recommendations made to me for weight management and exercise.

Patient

Witness

Reviewed by Physician