LoCicero Medical Group
Multi-Specialty Private Practice

Weight Management
New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

How did you hear about the Weight Management programs?

I am a patient of the primary care practice · Friend · Internet Advertisement · Physician Referral

Patient Name: _____

Address: _____
Street **City** **State** **ZIP Code**

E-mail Address: _____

Home Phone: (_____) _____ **Emergency Phone**: (_____) _____

Date of Birth: _____ **Sex**: M / F **Marital Status**: _____

Social Security #: _____ **Student**: Y / N **If yes**: Full- or Part-Time

Are you Hispanic or Latino? Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street **City** **State** **ZIP Code**

Phone: (_____) _____ **Extension**: _____

Emergency Contact: _____

Primary Phone: (____) _____ Alternate Phone: (____) _____

Address: _____
Street **City** **State** **ZIP Code**

PATIENT NAME: _____ DATE: _____

PERSONAL HISTORY

ILLNESS: Do you have or have you ever had:
Please encircle all answers-no or yes

Measles……..no yes
German Measles…….no yes
Mumps……no yes
Chicken Pox……no yes
Whooping Cough……no yes
Scarlet fever or Scarleting…..no yes
Diptheria…….no yes
Smallpox…….no yes
Pneumonia……..no yes
Influenza…….no yes
Pleurisy……...no yes
Rheumatic Fever or
Heart Disease……..no yes
Arthritis or Rheumatism…….no yes
Any Bone or Joint Disease….no yes
Neuritis or Neuralgia……..no yes
Bursitis, Sciatica or
Lumbago…….no yes
Polio or Meningitis……no yes
Gonorrhea or Syphilis……no yes
Anemia……no yes
Jaundice……..no yes
Epilepsy……..no yes
Migraine Headaches……...no yes
Tuberculosis……no yes
Diabetes……..no yes
Cancer……..no yes
High or Low
Blood Pressure……no yes
Ulcer……...no yes
Hepatitis……..no yes
Nervous breakdown……no yes
Food, chemical or
Drug poisoning……...no yes
Hay fever or Asthma……..no yes
Hives or Eczema…….no yes
Frequent infections or boils…no yes
Frequent colds or sore throat..no yes

ALLERGIES: Are you allergic to:

Penicillin or Sulfa…… …no yes
Asprin, Codine or
Morphine……no yes
Mycins or other Antibiotics...no yes
Tetanus Antitoxins or
Serums……no yes
Other:_____
_____
_____
_____

INJURIES: Have you had any:

Broken or cracked bones……no yes
Concussion or head injury…..no yes

WEIGHT: Now:_____
One year ago:_____
Maximum:_____When:_____

TRANSFUSIONS: Have you
Ever had:
Blood or Plasma
Transfusion……..…no yes
Date:_____

SURGERY: Have you had:
Appendectomy……no yes
Any other operation……no yes
_____
_____
_____
_____
_____
_____
_____

Have you ever been advised to have any surgical operation which has not been done……no yes
Give details:_____
_____
_____
_____
_____
_____

Have you been treated or hospitalized for any other illness not previously mentioned…….no yes
Give details:_____
_____
_____
_____
_____

X-RAYS: Have you ever had
X-rays of:
Chest……..no yes
Stomach or colon……...no yes
Gall Bladder……...no yes
Extremities……..no yes
Back……no yes
Mammograms(F)……no yes

EKG: Have you ever had an
Electrocardiogram?……no yes
Date:_____

IMMUNIZATIONS: Have you had:
Tetanus Shots……..no yes
Date Last
Tetanus:_____

SYSTEMS REVIEW:

EYES

Eye Strain……..……no yes
Seeing Double…….no yes
Seeing Halo about Lights…...no yes

EARS:
Hearing loss……no yes
Infections……no yes
Ringing in ears……no yes
Earache or discharge……...no yes

THROAT AND MOUTH:
Frequent sore throats……..no yes
Hoarseness……..no yes
Bleeding gums……no yes

NECK:
Goiter……..no yes
Lump or Swelling…..……..no yes
Pain or Stiffness……..no yes

BREAST:
Lump……...no yes
Discharge……no yes
Pain…….no yes

HEART AND LUNGS:
Chronic cough……no yes
Coughing up blood……..no yes
Shortness of breath……no yes
Night sweats……..…..no yes
Chest pain or pressure……no yes
Palpitations or fluttering…….no yes
Swollen ankles……no yes

INTESTINAL:
Loss of appetite……...no yes
Trouble swallowing……no yes
Nausea or vomiting……no yes
Vomiting blood……..…..no yes
Pain in abdomen…….no yes
Gall bladder trouble……no yes
Belching or bloating……...no yes
Change in bowel habits……..no yes
Constipation……no yes
Diarrhea……..no yes
Blood in stool or
Hemorrhoids……...…no yes
Black (tarry) stools……no yes

KIDNEY, BLADDER AND GENITALS:

Albumin or sugar in
Urine……...no yes
Blood or puss in urine…….no yes
Kidney or bladder
Infection……..no yes
Getting up nights to urinate
(_____ times)……no yes
Trouble starting urine
Stream…….no yes
Discharge……no yes

PATIENT NAME: _____ DATE: _____

MENSTRUATION:(women)
Age of onset of periods_____
When was your last period_____
When was your previous period_____
How long is your period_____days
How many pads per day_____
Usual interval between periods_____days
Bleeding between periods.…no yes
Pain with periods……no yes

NEUROLOGICAL:
Frequent headaches……no yes
Fainting spells……no yes
Convulsions……no yes
Paralysis or weakness…….no yes
Dizzy spells……no yes

EXTREMITIES:
Arthritis……..no yes
Any varicose veins…….no yes
Cramps in legs……no yes

GENERAL:
Unusual fatigue……..no yes
Unusual weakness……..no yes
Abnormal thirst……..no yes
Unable to sleep……..no yes
Anemia……..no yes
Swolen glands……no yes
Skin trouble……no yes
Back pain……no yes

HABITS:
Coffee_____cups per day
Smoking:
Cigarettes:_____packs per day
Cigars:_____Pipes:_____

Alcoholic beverages:
Present:
Light____Moderate____Heavy____
Past:
Light____Moderate____Heavy____

Work:_____hours per day

Regular exercise…….no yes

MEDICATIONS: Please list all medications:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Laxatives:
Never___Occ___Freq___Daily____
Vitamins:
Never___Occ___Freq___Daily____
Tranquilizers:
Never___Occ___Freq___Daily____
Sleeping pills or sedatives:
Never___Occ___Freq___Daily____
Cortisone, ACTH:
Never___Occ___Freq___Daily____
Antacids/Tums,Maalox,etc:
Never___Occ___Freq___Daily____

Heart tablets……no yes

Thyroid: Never___ Yes in past – none now___
Now on _____grams daily

Appetite suppressants:
Never___Occ___Freq___Daily____

Have you ever taken insulin for diabetes……...no yes

Have you ever taken hormone shots or tablets……no yes

Any other information that may be helpful:_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

REASON FOR TODAY'S VISIT:

1._____

2._____

3._____

Routine check-up
No Symptoms_____

FAMILY HISTORY:
IF LIVING:

	AGE	HEALTH
Father_____		
Mother_____		
Brother/Sister_____		
_____		
_____		
_____		
Husband/Wife_____		
Son/Daughter_____		
_____		
_____		
_____		

IF DECEASED:

	AGE AT DEATH	CAUSE
Father_____		
Mother_____		
Brother/Sister_____		
_____		
_____		
_____		
Husband/Wife_____		
Son/Daughter_____		
_____		
_____		
_____		

HAS ANY BLOOD RELATIVE EVER HAD: WHO

Cancer	no	yes
Tuberculosis	no	yes
Diabetes	no	yes
Heart trouble	no	yes
High blood Pressure	no	yes
Bleeding Tendency	no	yes
Stroke	no	yes

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Patient Name: _____ **Date**: _____

Self-Assessment Form

1. Most current weight: _____ lbs.
2. Weight one year ago: _____ lbs.
3. Highest adult weight: _____ lbs.
4. Lowest adult weight: _____ lbs.
5. Lowest weight held for more than 2 years: _____ lbs.
6. Most comfortable weight: _____ lbs.
7. Have you ever taken medication for weight control? Yes / No
8. If yes, which medications?
   _____
   _____

9. Have you ever enrolled in a commercial weight program? Yes / No
10. If yes, which program(s) and when?
    _____
    _____

11. Have you lost a large amount of weight in the past? Yes / No
12. How much weight did you lose? _____ lbs.
13. How long did you keep it off? _____
14. Do you exercise regularly? Yes / No
15. Please describe your usual regimen, including which exercises, how many times per week, and for how long:
    _____
    _____
    _____
    _____

16. List any vitamin and/or mineral supplements taken daily:
    _____
    _____
    _____
    _____

17. Do you smoke cigarettes? Yes / No
18. If yes, how many cigarettes do you smoke in one day? _____
19. How many meals do you eat out in restaurants per week? _____
20. How many take-out meals do you order each week? _____
21. How many meals dor you cook for yourself each week? _____
22. How many alcoholic beverages do you consume each week? _____

Patient Name: _____ **Date**: _____

23. Please check off any of the dietary problem areas listed below that apply to you:

_____ Meal skipping
_____ Carbohydrate craving
_____ Large portion sizes
_____ Too much alcohol
_____ Frequent snacking
_____ Eating foods high in fat
_____ Eating too many meals out in restaurants
_____ Eating for reason other than hunger

24. Do you ever binge on food? Yes / No
25. Have you ever made yourself vomit after a meal? Yes / No
26. Have you ever been treated for bulimia? Yes / No
27. Have you ever fasted to lose weight? Yes / No
28. Do you ever fear food and the calories it contains? Yes / No
29. Have you ever been treated for anorexia nervosa? Yes / No
30. Please describe the goals you would like to achieve with our professional support:

Patient Name: _____ **Date**: _____

Personal Health Profile Evaluation Checklist

My weight in pounds is: _____

My height in inches is: _____

My BMI* is: _____

*BMI = $\frac{\text{weight in pounds x 703}}{\text{height in inches}^2}$

My waist size in inches is: _____

My weight puts me at an: ☐ increased ☐ high
☐ very high ☐ extremely high risk for health problems.

Use the chart to the below to see whether your weight puts you at increased risk for health problems. Find your BMI in the left hand column. Then locate your waist size in one of the top columns. The box where the two meet shows your level of risk.

Body Mass Index (BMI)		Waist less than or equal to 40 in. (men) or 35 in. (women)	Waist greater than 40 in. (men) or 35 in. (women)
18.5 or less	Underweight	--	N/A
18.5 – 24.9	Normal	--	N/A
25.0 – 29.9	Overweight	Increased	High
30.0 – 34.9	Obese	High	Very High
36.0 – 39.9	Obese	Very High	Very High
40 or greater	Extremely Obese	Extremely High	Extremely High

Patient Name: _____ **Date**: _____

Information from my primary health care provider:

My blood pressure: _____

My blood cholesterol: _____

My HDL cholesterol: _____

My LDL cholesterol: _____

My blood triglyceride level: _____

My fasting blood sugar: _____

If your health care provider says these values are outside healthy ranges, you can improve them by losing and maintaining a moderate weight loss goal of five to 10 percent of your body weight and increasing your physical activity level.