NEW PATIENT REGISTRATION

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

Last Name: _____ First Name: _____

Date ofBirth: _____ Social Security Number: _____

Address: _____ Home Phone: _____

City: _____ State: ____ Zip: _____ Cell Phone: _____

Email: _____ Sex: Male Female Other

Ethnicity: African American Asian White/Caucasian **Race:** American Indian Asian White

Hispanic/Latino Other Prefer Not To Answer Black or African American Other

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

Employer: _____ Work Phone: _____

Primary Physician: _____ Phone #: _____

Pharmacy: _____ Phone #: _____

Referring Physician:_____ Phone #: _____

Emergency Contact: _____ Phone #: _____

PRIMARY INSURANCE: Cardholder Name: _____

Company: _____ ID #: _____

Group #: _____ Insurance Phone #: _____

SECONDARY INSURANCE: Cardholder Name: _____

Company: _____ ID #: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Health History and Review of Systems (Please check all that apply)

Constitutional

Fatigue / Tiredness	
Fever	
Skin	
Skin Cancer	
Chronic rash	
Psoriasis / Eczema	

Asthma – Year diagnosed __	
Shortness of breath at rest / activity	
Flights of stairs you can climb ____	
COPD / Emphysema	
Snoring	
Difficulty sleeping flat	
Awakening at night	
Morning headaches	
Daytime drowsiness	
Observed apnea episodes	
Chronic insomnia	
Sleep Apnea – Year diagnosed ____ CPAP BiPAP	

Cardiovascular

Chest pain at rest / activity	
Heart attack (MI) – Year diagnosed __	
Irregular heartbeat – Year diagnosed _	
Heart Disease – Year diagnosed __	
Congestive Heart Failure – Year diagnosed _	
High Blood Pressure (HTN) – Year diagnosed _	
Pregnancy Induced HTN	
Pacemaker / Defibrillator	
History of heart surgery	
High cholesterol / Triglycerides – Year diagnosed_	
Deep vein thrombosis (blood clot)	
Painful varicose veins	

Gastrointestinal

Heartburn / Reflux – Yr. diagnosed ___	
Difficulty swallowing	
Painful swallowing	
Hoarseness	
Peptic Ulcer Disease	
Frequent nausea	
Frequent vomiting	
Chronic abdominal pain	
Chronic diarrhea	
Chronic constipation	
Irritable Bowel Syndrome	
Crohn's Disease	
Ulcerative Colitis	
Cirrhosis	
Fatty liver	
Elevated liver enzymes	
Hepatitis A B C Not sure	
Hernia – Year diagnosed ____ Hiatal Inguinal Umbilical Ventral	

Musculoskeletal

Swelling of legs /feet	
Osteo-Arthritis	
Rheumatoid Arthritis	
Lupus	
Scleroderma	
Joint pain Limits ability to walk or exercise Ankles Knees Feet Hips Back	
Herniated Disc	

Hematologic/Lymphatic

Anemia, Type_____	
Blood clotting problem	
Sickle Cell Disease	
HIV – Year diagnosed _____	

Female Health

Infertility	
Facial hair growth	

Male Health

Prostate Cancer	
Enlarged breast tissue	

Neurological

Seizures	
Narcolepsy	
Stroke	
Migraine	
Fibromyalgia	
Multiple Sclerosis	

Psychological

Depression	
Anxiety Disorder	
Suicidal thoughts	
Suicide attempts	
Bi-Polar Disease	
Obsessive Compulsive Disorder	
Schizophrenia	
Anorexia	
Bulimia	
Binge eating	

Genitourinary

Frequent urination	
Urine leakage when coughing or laughing	
Kidney Disease	
Kidney Stones	
Blood in urine	
Painful urination	

Endocrine

Hyperthyroidism (High)	
Hypothyroidism (Low)	
Goiter	
Diabetes – Year _____ Type 1 or Type 2	
Chronic steroid use	
Cushing's Disease	
MTC	
MEN II	

ALLERGIES:

Have you or any of your family members had an adverse reaction to anesthesia? ☐ Yes ☐ No

Do you have any allergies? Yes ☐ No ☐

Allergic to any medications? Yes ☐ No ☐

Allergic to latex? Yes ☐ No ☐

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Current Medications

Medications, Vitamins, and Supplements

Please list all medications (over the counter and prescribed), vitamins and supplements you are currently taking.

Name of Medication/Supplements	Dosage	Frequency	Start Date	Reason		Notes (for provider use only)

Weight Loss History

How many years have you been overweight? _____ Have you had weight loss surgery? ☐ Yes (describe below) ☐ No

Weight Loss Surgery Type	Date	Surgeon	Weight Loss / Gain
			☐ Loss_____lbs ☐ Gain_____lbs
			☐ Loss_____lbs ☐ Gain_____lbs

Diet Programs and Supplements (Please indicate which of the following diets or plans you have attempted.)

Program	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
		Yes No	Loss_____lbs Gain_____lbs
		Yes No	Loss_____lbs Gain_____lbs
		Yes No	Loss_____lbs Gain_____lbs
		Yes No	Loss_____lbs Gain_____lbs
		Yes No	Loss_____lbs Gain_____lbs

Weight Loss Medication History (Please indicate which of the following diets or plans you have attempted.)

Medication	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
Phentermine (Adipex, Fastin, Pondimen)		Yes No	Loss_____lbs Gain_____lbs
GLP 1 Agonist (Oxempic, Monjauro,Trulicity, Victoza, Rybelsus, Wegovy, Zepbound		Yes No	Loss_____lbs Gain_____lbs
Xenical (Orlistat)		Yes No	Loss_____lbs Gain_____lbs

Non-Dietary Therapies (Please indicate which of the following diets or plans you have attempted.)

Therapy	Dates From / To	Was it Medically Supervised?	Weight Loss / Gain
Regular Exercise		Yes No	Loss_____lbs Gain_____lbs
Behavior Modification		Yes No	Loss_____lbs Gain_____lbs

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____

Family / Social / Surgical History

Surgical History (Please list all minor and/or major surgical procedures and operations excluding weight loss surgery.)

Procedure	Date	Reasons

Family History (Please indicate family members diagnosed with the following illnesses)

	Mother	Father	Maternal G-mother	Maternal G-father	Paternal G-mother	Paternal G-father	Sibling 1	Sibling 2	Sibling 3
Is this person living?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Age at death									
Cause of death									
Obesity									
Cancer									
Diabetes									
Hypertension									
Heart Attack									
Heart Disease									
High Cholesterol									
Malignant Hyperthermia									
Stroke									
Unknown History									

Smoking	Dipping	Alcohol	Illicit / Illegal Drug Abuse
☐ Current ☐ Past	☐ Current ☐ Past	☐ Current ☐ Past	☐ Current ☐ Past
Packs per day _____	Dips per day _____	Drinks per day _____	Substance _____
# of years _____	# of years _____	# of years _____	# of years _____
Last used _____	Last used _____	Last used _____	Last used _____

Provider's Signature:_____**Date:**_____/_____/ _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____