NEW PATIENT REGISTRATION

ALL INFORMATION ON THIS FORM MUST BE COMPLETED

Last Name: _____ **First Name:** _____

Date of Birth: _____ **Social Security Number:** _____

Address: _____ **Home Phone:** _____

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

Email: _____ **Sex:** ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ African American ☐ Asian ☐ White/Caucasian ☐ Hispanic/Latino ☐ Other ☐ Prefer Not to Answer

Race: ☐ American Indian ☐ Asian ☐ White ☐ 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 #:** _____

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature (if applicable): _____

Patient Name: _____ **Date of Birth:** _____

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

Constitutional

- Fatigue / Tiredness
- Fever

Skin

- Skin Cancer
- Chronic Rash
- Psoriasis / Eczema

Respiratory

- Asthma – Year diagnosed: _____
- Shortness of Breath: ☐ at rest / ☐ with 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 / ☐ with 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 – Year Diagnosed: _____
- Difficulty Swallowing
- Painful Swallowing
- Hoarseness
- Peptic Ulcer Disease
- Frequent Nausea
- Frequent Vomiting
- Chronic Abdominal Pain
- Chronic Diarrhea
- Chronic Constipation
- 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
- 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 Diagnosed: _____
  ☐ Type I or ☐ Type II
- Chronic Steroid Use
- Cushing's Disease
- Medullary Thyroid Cancer (MTC)
- Multiple Endocrine Neoplasia
  ☐ Type I or ☐ Type 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 Name: ____ **Date of Birth:** __________________

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
		☐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 Name: _____ **Date of Birth:** _____

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 _____

Save Data to File Submit Form via Email

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