# St. Francis Weight Loss Center

**and Franciscan Center for Integrative Health** Today's date: ____________

**Patient Name:** ______________________________________ Sex: Male Female

Social Security #:________________ Birthdate: __________ Mother's Maiden Name:_______________

Address:_______________________________________________________________________________

City/State/Zip: ______________________________________________________________________

Home Phone:_________________ Work Phone:_________________ Cell Phone:__________________

May we leave a message on voice mail? ___Yes ____No Best number to contact you? ___________________________________

**Marital Status**: Married Single Divorced Widowed **Ethnicity**: Hispanic Non-Hispanic

**Race**: American Indian Asian African American Native Hawaiian White Other

**Referral or Primary Care Physician**: _________________________________________________________

Address:____________________________________________________________________________

**Employer**: _________________________________ Occupation: _______________ Full-time Part-time

Employer Address: ___________________________________ City/State/Zip:________________________

If Patient is a minor, lives with:_______________________________ Relationship:_____________________

**Spouse Name**:___________________________________________ Sex: Male Female

Social Security #: _____________________________________ Birthdate: _____________________________

Employer:_____________________________________________Phone:___________________________

**WHO SHOULD RECEIVE THE BILL (AFTER INSURANCE PAYS)**

Name: ______________________________________ Relationship to patient:___________________________

Social Security #: ____________________ Birthdate: ________________ Sex: Male Female

Address:_________________________________________________________ Phone:___________________

Employer:_________________________________________________ Work Phone:____________________

**EMERGENCY CONTACT**

Name:__________________________ Relationship to patient______________ Legal Guardian YES NO

Address:__________________________________________Home Phone: ___________ Work Phone_______

**MEDICAL INSURANCE INFORMATION**

**Primary Insurance**:_______________________________________________ Eff date: ________________

Policy Holder's Name_____________________________________ Relationship to patient:______________

Policyholder's Birth Date:______________________ Social Security #: ______________________________

Policyholder's Address (if different from patient address):__________________________________________

**Secondary Insurance**:_____________________________________________ Eff date:__________________

Policy Holder's Name:____________________________________Relationship to patient: ______________

Policyholder's Birth Date:______________________ Social Security #: ______________________________

Policyholder's Address (if different from patient address):__________________________________________

How did you hear about us? (circle one) TV Radio Family/Friend Physician Print-Add Other

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St. Francis Weight Loss Center

**and Franciscan Center for Integrative Health**

PATIENT HEALTH HISTORY

Patient Name: ___________________________ Age:____________________

Family Physician: _________________________ Physician Phone: ___________________

## Past/ Current Medical History

(Have you ever been diagnosed or are you currently under care for:)

| Past | Current | Disease | Past | Current | Disease |
|---|---|---|---|---|---|
| | | AIDS | | | Diverticulitis |
| | | Anemia | | | Drug Abuse |
| | | Alcoholism | | | Fibromyalgia |
| | | Anesthesia Reaction | | | Gallbladder Problems |
| | | Anorexia/Bulimia/ Binge Eating | | | Gastroesophageal Reflux |
| | | Anxiety/Depression | | | Glaucoma |
| | | Arthritis | | | Gout |
| | | Asthma | | | Hypertension |
| | | Autoimmune Disease | | | Infertility |
| | | Bleeding Disorder | | | Irritable Bowel Syndrome |
| | | Blood Clots | | | Liver Disease |
| | | Blood Transfusion | | | Hepatitis |
| | | Cardiac Disease | | | Fatty Liver |
| | | Arrhythmia | | | Kidney Disease |
| | | Angina | | | Kidney Stones |
| | | Heart Attack (MI) | | | Learning Disability |
| | | Congestive Heart Failure | | | Metabolic Syndrome |
| | | Pacemaker/ AICD | | | Migraine Headache |
| | | Rheumatic Fever | | | Nervous Breakdown |
| | | Valvular Disease | | | Suicide Attempt |
| | | Cellulitis | | | Osteoporosis |
| | | COPD/Emphysema | | | Pneumonia |
| | | Crohn's Disease | | | Polycystic Ovarian Syndrome |
| | | Cushing's Disease | | | Pseudotumor Cerebri |
| | | Diabetes | | | Seizure Disorder |
| | | Diabetic Eye Problems | | | Sleep Apnea |
| | | Diabetic Kidney Problems | | | Stroke |
| | | Diabetic Neuropathy | | | Thyroid Disease |
| | | √ Blood sugars @ home | | | Ulcers |
| | | Diabetic Education Classes | | | Vaginal Bleeding-abnormal |
| | | Insulin pump | | | High Cholesterol/Triglycerides |
| | | Glucagon Kit | | | Cancer-Type |
| | | Low/High Sugar reactions | | | ______________________ |

| | Allergies | |
|---|---|---|

Do you have any allergies to Drugs, environmental Agents, Food Agents, or Latex?

_____**No** Known Allergies _____ **Yes** I have the following allergies: Please list all and reaction.

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |

| | Medications | |
|---|---|---|

Please list ALL Medications you are currently taking or have taken during the last 30 days. Please list actual dose and frequency.

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|---|---|---|---|---|---|
| 1. | | | 9. | | |
| 2. | | | 10. | | |
| 3. | | | 11. | | |
| 4. | | | 12. | | |
| 5. | | | 13. | | |
| 6. | | | 14. | | |
| 7. | | | 15. | | |
| 8. | | | 16. | | |

| | Vitamins/Minerals | | | |
|---|---|---|---|---|
| **Brand or other name** | **Reason** | **When started** | **Dosage per day** | **cost** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

| | All Surgeries (Lifetime) Hospitalizations (within last 2 yrs) | | |
|---|---|---|---|
| Type/Reason | Surgeon/Physician | Date | Complications |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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## Previous testing

| Test | Where | Date | Results |
|---|---|---|---|
| Upper Endoscopy | | | |
| Colonoscopy | | | |
| Cardiac stress test | | | |
| PSA (prostate) test (men) | | | |
| Sleep Apnea test | | | |

## For Women Only

Please complete the following:

a. Menstrual Cycle problems: ___Yes ___NO Explain: ___________________________________________
b. Number of Menstrual periods per year (if irregular):_______________________
c. Hysterectomy? ____Yes ____No Date: __________ Tubal ligation: ___Yes ___No Date: _________
d. Menopausal? ____Yes ___No Hot flashes ___Yes ___No
e. Problem having children? ___Yes ___No Explain: __________________________________________
f. # Pregnancies_________ # Children________ # Miscarriages_______ # Abortions___________
g. Pregnant now? ____Yes ____NO Date of last period: _________________
h. Date of last Mammogram: _____________________ Date of last Pap Smear: ____________________
i. Do you have any problems with acne ______facial hair_____ or scalp hair loss _________
j. Have you been diagnosed with Polycystic Ovarian Syndrome? ___Yes ___No If yes, explain:
_____________________________________________________________________________________

## Review of Systems

Are you currently bothered by:

| | | |
|---|---|---|
| _____ Headaches | _____ Chest Pain | _____ Urinary Incontinence |
| _____ Dizziness | _____ Palpitations | _____ Urinary Retention |
| _____ Visual Problems | _____ Passing Out | _____ Back Pain |
| _____ Hearing problems | _____ Abdominal Pain | _____ Joint Pain |
| _____ Swallowing difficulty | _____ Nausea/ Vomiting | _____ Swelling of legs |
| _____ Shortness of breath | _____ Diarrhea | _____ Skin Problems |
| _____ Chronic Cough | _____ Constipation | _____ Cold Intolerance |
| _____ Frequent colds/ sinus | _____ Indigestion | _____ Heat Intolerance |

## Immunizations

**Please provide dates last received:**

Pneumonia Vaccine _______ Tetanus _______ Flu _______ TB Skin test________

## Family History

Specific attention to High Blood Pressure, Diabetes, Heart Disease, High Cholesterol, Heart Disease, Cancer (Type), Sleep Apnea, Stroke, Gallbladder Disease, Thyroid Disease and Weight.

| | Age | Living/Deceased | Medical Problems: | Overweight (how much?) |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brother | | | | |
| Brother | | | | |
| Brother | | | | |
| Sister | | | | |
| Sister | | | | |
| Sister | | | | |

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| | Thrombosis Risk Factor | |
|---|---|---|
| √ Check | **Category** | **Score** |
| | Age above 40 | 1 |
| | Previous blood clot in legs (DVT) or Lungs (PE) | 3 |
| | Inability to walk more than a few steps | 1 |
| | Previous history of Cancer | 2 |
| | Obesity (BMI . 35=1/ BMI > 52=2) | 1 or 2 |
| | Heart Disease/ congested heart failure | 3 |
| | Varicose Veins | 1 |
| | Limb Trauma Injury | 1 |
| | Undergoing surgery (including bariatric) | 1 |
| | Hormaone replacement or Birth control pills | 1 |
| | History of Autoimmune Disease (Lupus, SLE, rheumatoid arthritis) | 1 |
| | Disease affecting the clotting of the blood | 2 |

**Score: 0-1=low risk 2-4=moderate risk >4=high risk** **TOTAL: _______________**

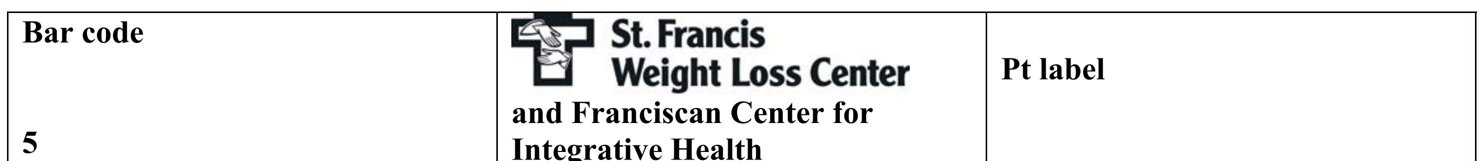
## Sleep Screening

**Please check the following as they apply to you:**

| | Question | YES | NO |
|---|---|---|---|
| 2 | Do you snore? | | |
| 2 | If you snore, do others say your snoring is interrupted by chocking/snoring sounds? | | |
| 2 | Do others say you stop breathing while you sleep? | | |
| 2 | Do you have trouble staying awake when you want to be awake? | | |
| 2 | Do you fall asleep during any of the flowing?<br>Watching TV: ___Never ___Rarely ____Sometimes ___Frequently<br>While at work: ___Never ___Rarely ____Sometimes ___Frequently<br>At the movies, church: ___Never ___Rarely ____Sometimes ___Frequently | | |
| 1 | Do you fall asleep frequently while reading books or newspapers? | | |
| 2 | Have you ever fallen asleep while driving? | | |
| 1 | Do you have trouble getting the sleep or staying asleep when you want to sleep? | | |
| 1 | Do you feel tired after 8 hours of sleep? | | |
| 1 | Do you frequently get less than 7 hours of sleep in 24 hours? | | |
| 1 | Do you have restless legs or crawling feelings in your legs when you sit or lie down? | | |
| 1 | Do others say you have jerking movements of your legs during your sleep? | | |

**5 or less=LOW 5-8=Moderate Above 8=High risk** **Total: ___________**

Do you have any other sleep related problems? ___yes ___No Explain: ________________________________
Use CPAP/BIPAP? ___Yes ___NO If yes, setting: ________



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## PERSONAL HISTORY

**Health Habits:**

1. Do you currently smoke? ___ Yes __No If yes, what do you smoke and how many a day? __________
2. Do you chew tobacco? ___Yes ___No
3. If you used tobacco products in the past when did you quit? ______________________
4. Do you drink alcohol? ___ Yes ___ No How Much and how often? ___________________
5. Do you now or have you ever used illegal drugs? ___Yes ___No Explain: _______________
6. Do you drink coffee or use caffeine products? ___Yes ___No If yes, how much per day? ___________
7. How many carbonated beverages do you drink per day? _________ Are they sugar free? ____________
8. Marital status: _____________
9. Do you have children? ___Yes ___NO Ages: ________________________
10. Do you wear any of the following? ___ Orthobraces ___Special shoes ___Hearing aids ___ Glasses
    ___ Dentures ___ Other, specify ______________________
11. Do you have problems reading or writing beyond the 6th grade level? ___Yes ___ No
12. Highest level of education completed? _______________________________________________
13. What is your occupation: _________________________
14. Do you lift heavy objects in your job? ___Yes ___No
15. Please list your hobbies, recreational activities, or any other job activities you may be involved.________________________________________________________________________________
16. In your words, please tell us what your general health goals are and what improvements you would like to make?
    ____________________________________________________________________________________
    ____________________________________________________________________________________
    ____________________________________________________________________________________
17. What prior experience have you had with alternative medicine?
    ____________________________________________________________________________________
18. **Concerns**(Please rank priority)

| **Concerns**(Please rank priority) | **Onset** | **Frequency** | **Severity**(mild/severe) |
|---|---|---|---|
| ________________________________ | _______ | ____________ | _________ |
| ________________________________ | _______ | ____________ | _________ |
| ________________________________ | _______ | ____________ | _________ |
| ________________________________ | _______ | ____________ | _________ |

## Authorization

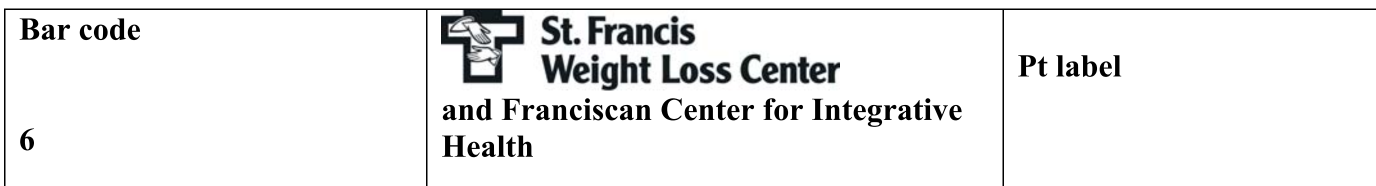
I certify that all the information I provide is true and complete to the best of my knowledge. I understand that it is important the staff has a complete and accurate information in order to provide safe medical evaluation and care. I understand this medical history is used in providing care through the Weight Loss Center and that some information may need to be shared with referring physicians and counselors. We may fax this information to other departments within St Francis health Care system as need to proved safe care to you though out this process.

_____________________________________________ ________/________/________

Signature Date

As part of the weight loss program, we may periodically obtain pictures. I agree that my pictures may be used for statistical/educational purposes.

_________________________________________________ ________/________/__________



## Nutrition and Weight Loss History

1. Present weight: ____________ Height:__________________ Desired weight:_____________
2. In what time frame would you like to be at your desired weight? _________________________
3. How confident are you that you will reach this goal?
   Very Somewhat Slightly Not
4. Were you overweight as a young child (less that 5 years old)? YES NO
   Did you gain much weight during elementary school? YES NO
   Did you gain much weight during middle school? YES NO
   Did you gain much weight in high school? YES NO
5. Approximate weights:
   Age 14 _______ Age 20 _________ Age 30 __________
   Age 40 _______ Age 50 _________ Age 60 __________ Age 70 ______
6. Women commonly retain weight with each pregnancy. Please approximate the amount you gained with each pregnancy and the amount of weight you kept 6 months after delivery (retained weight). (Example: gained 35 lbs with pregnancy and kept or retained 10 of those pounds)

| | Age | Pregnancy weight gain | Retained weight |
|---|---|---|---|
| 1st Pregnancy | ___ | __________________ | _____________ |
| 2nd Pregnancy | ___ | __________________ | _____________ |
| 3rd Pregnancy | ___ | __________________ | _____________ |
| 4th Pregnancy | ___ | __________________ | _____________ |

7. When did you begin gaining excess weight? Give reasons if known.
   ______________________________________________________________________
8. What is your main reason for your decision to lose weight?
   ______________________________________________________________________
9. Can you count on your family for support to help you achieve your goals? YES NO
10. What has been your maximum (non-pregnant) weight and when? ________________________________
11. Have you ever attempted to lose weight before? YES NO
12. What is the most you have ever lost? ___________________________________________________
13. This loss was over what time period? __________________________________________________
14. Have you ever taken appetite suppressant medication? YES NO
    Over the counter (type) ___________________________________
    Prescription (type) _______________________________________
15. Is your significant other overweight? YES NO If yes, how much overweight? ________________
16. Do you awaken hungry during the night? YES NO
    What do you do? _________________________________________________________________
17 What are your worst food habits? (Ex: food choices, snacking, portions, etc.)
   ______________________________________________________________________
   ______________________________________________________________________
18 Snack Habits
   What: ______________________ How much:____________________ When:_____________________
19. When you are under a stressful situation at work or family related, do you tend to eat more? YES NO
    Explain: _________________________________________________________________________
20. Are you currently undergoing a stressful situation or emotional upset? YES NO
    Explain: _________________________________________________________________________
21. Do you frequently eat what others would consider an abnormally large amount of food? YES NO
    When? ______________________________ How often? ___________________________________

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22. Do you feel unable to control what or how much you eat? YES NO
Do you eat much more rapidly than other people? YES NO
Do you eat until uncomfortably full? YES NO
Do you eat large amounts of food when not physically hungry? YES NO
Do you eat alone out of embarrassment at the quantity of food eaten? YES NO
Do you have feelings of disgust, depression or guilt after overeating? YES NO
Do you make yourself vomit or use laxatives/diuretics to control weight? YES NO

23. Describe your general energy level: ____________________
Please describe: ____________________

24. What is your occupation?____________________

25. Do you get physical activity in the workplace? ____________________

26. Do you exercise? __ Yes __ No If yes, what type and how often? ____________________
____________________

27. Do you belong to any fitness facilities? __yes __no If yes, name of facility: ____________________

28. Do you have any exercise equipment at home? __Yes __ No If yes, type: ________________

29. Do you use a personal trainer? __ Yes __No

30. Are there any barriers to that prevent you from exercising or walking?
____________________

30. Activity Level: Choose one
________ Inactive, no regular physical activity with a sit down job
________ Light Activity, no organized physical activity during leisure time
________ Moderate Activity, involved in activities such as weekend golf, tennis, etc. 2-3x/week
________ Heavy Activity, consistent lifting, stair climbing, heavy construction or regular participation in jogging, swimming, cycling or active sports at least 4-5x/week
________ Vigorous Activity, participation in extensive physical exercise for at least 60 minutes, 5 or more times per week

**Instructions:**

Please list ALL diets or methods of weight loss you have tried. Please be sure to include all physician and registered dietitian supervised programs.

**Check all the boxes that apply to you:**

__Medifast __Optifast __Jenny Craig __Richard Simmons __Weight Watchers
__ Nutri-systems __Pritikin __T.O.P.S. __Scarsdale __Herbal Life
__Susan Powers __Cal Ban 3000 __Accutrim __Sweet Success __The Zone Diet
__Slimfast __Beverly Hills __Physicians Weight Loss center __ Dieters Tea
__Adkins __Cal Slim __Diurex __Ampetamines __Fen-Phen
__ Hypnosis __Thyroid Supp __ Fat Burners __Cambridge __Hypnosis
__ Cabbage Soup __Stillman __ Dexatrim __ Gastric Bubble __Acupuncture
__Jaw wiring __Injections (__B-6,__ B-12,__ HCG,__ Urine,__other) __LEARN program

**Physician and/or Registered Dietitian Supervised Weight Loss Attempts**

| Name of Doctor or Dietitian | Medication | Date started | Date stopped | Weight Lost (lbs) | Type of Diet | Any problems? | Regained Weight (lbs) |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |