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PATIENT DEMOGRAPHICS

Street Address: ______________________________

City, State, Zip: ____________ Email Address: ____________

Home Phone: ____________ Date of Birth: ____________

Work Phone: ____________ Social Security No.: ____________

Cell Phone: ____________ Marital Status: ☐ S ☐ M ☐ W ☐ D

Employer: ____________ Occupation: ____________

Emergency Contact: ______________________________

Relationship to You: ____________ Phone: ____________

Primary Insurance:

Insurance Company: ____________ Policy Holder Name: ____________

Claims Address: ____________ Policy Holder SSN#: ____________

City, State, Zip: ____________ Policy Holder DOB: ____________

Insurance Phone No.: ____________ Relationship to Patient: ____________

Insurance ID No.: ____________ Group No.: ____________

Secondary Insurance:

Insurance Company: ____________ Policy Holder Name: ____________

Claims Address: ____________ Policy Holder SSN#: ____________

City, State, Zip: ____________ Policy Holder DOB: ____________

Insurance Phone No.: ____________ Relationship to Patient: ____________

Insurance ID No.: ____________ Group No.: ____________

Please list any individual(s) you authorize our office to release your medical information to:

____________________ Relationship: ____________

____________________ Relationship: ____________

____________________ Relationship: ____________

____________________ Relationship: ____________

Signature: ____________________ Date: ____________

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PATIENT INFORMATION

Date: ______________________________

Medical History:

Do you prefer to be called by another name? ______________________________

Age: __________ Gender: __________ Height: __________

Present Weight: __________ Usual Weight: __________ Greatest Weight: __________

Primary Care / Family Doctor: ______________________________

Phone Number: ______________________________

Doctor who referred you: ______________________________

Phone Number: ______________________________

Have you ever been seen by a Cardiologist (Heart Doctor)? ☐ Yes ☐ No

Doctor's Name: ____________________ Phone: ____________________

Reason: ______________________________

Have you ever been seen by a Pulmonologist (Lung Doctor)? ☐ Yes ☐ No

Doctor's Name: ____________________ Phone: ____________________

Reason: ______________________________

Are there other Doctors you are currently seeing? ☐ Yes ☐ No

Doctor's Name: ____________________ Phone: ____________________

Reason: ____________________ Last Seen: ____________________

Doctor's Name: ____________________ Phone: ____________________

Reason: ____________________ Last Seen: ____________________

What is the reason for your visit? ______________________________

____

What are your symptoms and when did they start? ______________________________

____

____

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Please list your Hospitalizations:

Illness Kind / Type	Year	Hospital / City

Operation Kind / Type	Year	Hospital / City

Family History:

	Stroke	High Blood Pressure	Diabetes	Heart Disease	Cancer / Type	Age at Death / Cause of Death
Mother	☐	☐	☐	☐	☐ ________	________
Father	☐	☐	☐	☐	☐ ________	________
Brother/Sister	☐	☐	☐	☐	☐ ________	________
Brother/Sister	☐	☐	☐	☐	☐ ________	________
Grandmother	☐	☐	☐	☐	☐ ________	________
Grandfather	☐	☐	☐	☐	☐ ________	________

Other Family Medical Problems: ________________________________

____

Do you currently smoke? ☐ Yes ☐ No How much per day: ____________

Have you smoked in the past? ☐ Yes ☐ No When did you stop: ____________

Do you currently drink alcohol? ☐ Yes ☐ No How much per week: ____________

Do you currently use drugs? ☐ Yes ☐ No

Do you or have you in the past abused drugs? ☐ Yes ☐ No

For Women:

Are you pregnant? ☐ Yes ☐ No Expected delivery date: ____________

Date of last menstrual period? ________________________________

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Current Medications – Prescription and Non-Prescription:

Please list all over the counter (non-prescription) and prescription medications including Vitamins and Herbal Supplements that you are currently taking. Also, remember to include those that can cause bleeding. Some examples are (but not limited to) Aspirin, Ibuprofen, Excedrin, Advil, Motrin, Aleve, Orudis, etc.

Name of Medication	Dose	How Often

If your answer is yes to any of the below, please list above.

Do you take Aspirin?	☐ Yes	☐ No
Do you take Advil (Ibuprofen)?	☐ Yes	☐ No
Do you take ANY Vitamins?	☐ Yes	☐ No
Do you take Diet Medications / Herbs / Tea?	☐ Yes	☐ No
Do you take St. Johns Wort, Melatonin or Ephedra?	☐ Yes	☐ No
Do you take Ginseng, Kava, Valerian or Black Cohosh?	☐ Yes	☐ No
Do you take Garlic Supplements, Ginko, Fish Oil or Vitamin E?	☐ Yes	☐ No

Allergies:

☐ Peanut Allergy ☐ Latex Allergy ☐ Shellfish Allergy

☐ **No** Drug Allergies ☐ **Yes** Drug Allergies (Please Explain / List All Below)

____

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Health History:

☐ Y ☐ N Headaches	☐ Y ☐ N Stroke	☐ Y ☐ N Heart Disease
☐ Y ☐ N Hearing Loss	☐ Y ☐ N Depression	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Seizures	☐ Y ☐ N Convulsions	☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Poor Vision	☐ Y ☐ N Mental Illness	☐ Y ☐ N Phlebitis
☐ Y ☐ N Kidney Problems	☐ Y ☐ N Kidney Stones	☐ Y ☐ N Chest Pain
☐ Y ☐ N Kidney Infection	☐ Y ☐ N Burning on Urination	☐ Y ☐ N Heart Murmur
☐ Y ☐ N Frequent Urination	________ # of Night Urination	☐ Y ☐ N Abnormal Heart Beat
☐ Y ☐ N Shortness of Breath	☐ Y ☐ N Asthma / Emphysema	☐ Y ☐ N Varicose Veins
☐ Y ☐ N Hoarseness	☐ Y ☐ N Lung Disease	☐ Y ☐ N Sore Throat / Cough
☐ Y ☐ N Arthritis	☐ Y ☐ N Diabetes	☐ Y ☐ N Thyroid Trouble
☐ Y ☐ N HIV	☐ Y ☐ N Bleeding Disorders	☐ Y ☐ N Nosebleeds
☐ Y ☐ N AIDS	☐ Y ☐ N Alcoholism	☐ Y ☐ N Cancer
☐ Y ☐ N Gout	☐ Y ☐ N Chills / Fever	☐ Y ☐ N Rash
☐ Y ☐ N Breast Lump	☐ Y ☐ N Breast Pain	☐ Y ☐ N Nipple Discharge
☐ Y ☐ N Anemia	☐ Y ☐ N Blood in Stool	☐ Y ☐ N Jaundice
☐ Y ☐ N Liver Disease	☐ Y ☐ N Stomach Ulcers	☐ Y ☐ N Poor Appetite
☐ Y ☐ N Nausea / Vomiting	☐ Y ☐ N Gallbladder Disease	☐ Y ☐ N Gallstones
☐ Y ☐ N Stomach Pain	☐ Y ☐ N Difficulty Swallowing	☐ Y ☐ N Heartburn
☐ Y ☐ N Change in Bowel Habits	☐ Y ☐ N Constipation	☐ Y ☐ N Diarrhea
☐ Y ☐ N Hemorrhoids	☐ Y ☐ N Sickle Cell Anemia	

Please Explain all Yes Answers:

____

____

____

Reaction to Anesthesia? ☐ Never Had Anesthesia ☐ Yes (Please Explain Below) ☐ No

____

Reviewed with patient:

____

Daryl D. Wier, M.D. FACS / Date / Time

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PATIENT DEMOGRAPHICS – FORM 1

It is important for your future treatment and care that all of this information be filled in accurately and completely. All items on demographics form must be filled in completely for patient medical records.

MRN: ______________________ Date of Visit: ______________________

First Name: ______________________ Last Name: ______________________

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr Date of Birth: ______________________

Address1: ______________________

Address2: ______________________

City: ______________________ State: __________ Zip Code: __________

Country: ______________________

Email: ______________________

Phone-Home: ______________________ Phone-Mobile: ______________________

Phone-Work: ______________________ Ext: ______________________

Gender:

☐ Female ☐ Male

Race:

☐ African American ☐ Caucasian ☐ Native American/Alaska Native

☐ Asian ☐ Hispanic ☐ Native Hawaiian/Pacific Islander

☐ Other ______________________

Religion:

☐ Catholic ☐ Jewish ☐ Protestant

☐ Christian ☐ Muslim ☐ Non-Denominational

Employment Status:

☐ Full Time ☐ Part Time ☐ Self Employed

☐ Disabled ☐ Unemployed ☐ Office/Admin

☐ Homemaker ☐ Physical Labor ☐ Student

☐ Professional ☐ Retired ☐ Other

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PRIMARY OR REFERRING PHYSICIAN INFORMATION – FORM 2

Important! Please fill in the following information for your Primary or Referring Physician.

MD First Name: ____________________ MD Last Name: ____________________

MD Specialty: ☐ PCP ☐ Gastro ☐ Gyn ☐ Cardio ☐ CCF ☐ Non-CCF ☐ Endocrinology

MD Address1: ____________________

MD Address2: ____________________

MD City: ____________________ MD State: __________ MD Zip: __________

Email: ____________________

Phone-MD: ____________________ Fax-MD: ____________________

Family History (What is the health status of your family?):

Mother:

☐ Living ☐ Deceased Medical Problems: ____________________

Father:

☐ Living ☐ Deceased Medical Problems: ____________________

Brother / Sister:

☐ Living ☐ Deceased Medical Problems: ____________________

Brother / Sister:

☐ Living ☐ Deceased Medical Problems: ____________________

Brother / Sister:

☐ Living ☐ Deceased Medical Problems: ____________________

Are any of your family illnesses related to YOUR chief complaint/or history of present illness?

☐ Yes ☐ No

Hereditary or High risk disease?

☐ Yes ☐ No

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PATIENT WEIGHT INFORMATION – FORM 3

MRN: ______________________ Date of Visit: ______________________

Last Name: ______________________

Weight loss medications:

☐ Phen-Fen ☐ Redux

Psych Counseling:

☐ Yes ☐ No

Weight Loss Programs:

Weight Watchers: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Richard Simmons: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Physician's Wt Loss: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Slimfast: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Jenny Craig: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Atkins: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Medifast: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Health Spa: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Exercise: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

Other: ☐ Yes ☐ No

Duration: ________ Year: ________ Weight Loss: ________ How Long? ________

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WEIGHT LOSS MEDICATIONS – FORM 4

Please list any weight loss medication you have been prescribed or taken:

1. Medication/Drug: ______________________________

   How long? ____________ Weight Loss: ____________

2. Medication/Drug: ______________________________

   How long? ____________ Weight Loss: ____________

3. Medication/Drug: ______________________________

   How long? ____________ Weight Loss: ____________

4. Medication/Drug: ______________________________

   How long? ____________ Weight Loss: ____________

5. Medication/Drug: ______________________________

   How long? ____________ Weight Loss: ____________

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REVIEW OF SYSTEMS

Constitutional:

☐ Fatigue ☐ Fever ☐ General Weakness ☐ Healthy

Other Comments: ______________________________

Eyes:

☐ Blurred Vision ☐ Normal ☐ Visual Disturbance

Other Comments: ______________________________

Ears/Nose/Mouth/Throat:

☐ Hearing ☐ Tinnitus ☐ Difficulty Swallowing ☐ Epistaxis ☐ Sinus

Other Comments: ______________________________

Endocrine:

Diabetes: Diabetes Type:

☐ Yes ☐ Take Tablets ☐ Insulin Dependent ☐ Pancreas

☐ No ☐ Diet Controlled ☐ Gestational Diabetes ☐ Adrenal

☐ Parathyroid ☐ Thyroid Disease ☐ Cancer

Other Comments: ______________________________

Circulatory:

HTN: Cardiovascular Disease:

☐ Yes ☐ Stroke ☐ High Cholesterol ☐ Thrombophlebitis

☐ No ☐ Heart Attack ☐ Congestive Heart Failure ☐ Venous Insufficiency

☐ Chest Pain ☐ Coronary Artery Disease

Other Comments: ______________________________

Neurologic:

Neurological Conditions:

☐ None ☐ Insomnia ☐ Encephalitis as Child ☐ Pseudotumor Cerebri

☐ Stroke ☐ Meningitis as Child

Other Comments: ______________________________

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Musculoskeletal:

Arthritis:
- ☐ None
- ☐ Osteoarthritis
- ☐ Rheumatoid

Muscle:
- ☐ Lupus
- ☐ Scleroderma
- ☐ Other

Muscle/Joint Pains:
- ☐ Joint Pains
- ☐ Foot /Ankle Pain
- ☐ Leg / Feet Swelling
- ☐ Orthopedic Surgery
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Carpel Tunnel
- ☐ Back Pain

Muscle/Joint Pain – other: ______________________

Arthritis Medication: ______________________

Orthopedic Surgery: ______________________

Other Comments: ______________________

Gastrointestinal:

Gastrointestinal Diseases:
- ☐ Cancer
- ☐ Pancreatitis
- ☐ Cholecystitis
- ☐ Peptic Ulcer
- ☐ IBD-Colon
- ☐ Fatty Liver
- ☐ Cholelithlasis
- ☐ GERD

Surgeries:
- ☐ Chole Open
- ☐ Chole Lap
- ☐ Jejuno-Ileal Bypass
- ☐ Colon Resection
- ☐ Appendectomy
- ☐ Hernia Repair
- ☐ Previous Bariactric Surgery
- ☐ Gastroplasty
- ☐ Other ______________________

Other Comments: ______________________

Psychologic:

Have you ever been treated for any of the following conditions?
- ☐ Anxiety
- ☐ Depression
- ☐ Manic Depressive Disorder
- ☐ Bipolar
- ☐ Schizophrenia

Does your weight affect your life? ☐ Yes ☐ No

How does your weight affect your life?
- ☐ Physically
- ☐ Financially
- ☐ Socially

Other Comments: ______________________

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Patient ID Label Here

Respiratory:

Breathing Problems:

☐ Asthma ☐ Sleep Apnea ☐ Shortness of Breath

☐ Snoring ☐ Cancer ☐ Difficulty Breathing

Other Comments: ______________________________

Epworth Sleepiness Scale:

0 = would never doze	Sitting and Reading ______	Sitting Quietly After Lunch ______
1 = slight chance of dozing	Rest in the Afternoon ______	Inactive ______
2 = moderate chance of dozing	Watching TV ______	Passenger in Car ______
3 = high chance of dozing	Sitting and Talking ______	In Car While Stopped ______

Epworth Score Total: ☐

Other Comments: ______________________________

Hematologic / Lymphatic:

List any type of cancer you may have had:

☐ Breast ☐ Prostate

☐ Lung ☐ Gyn

☐ Colon ☐ Other

Cancer Screen:

Colonoscopy Date ______________

GYN/Pap Date ______________

Mammogram Date ______________

Prostate Date ______________

Other Comments: ______________________________

Genitourinary (Male):

Genitourinary Problems:

☐ N/A ☐ Fecal Incontinence

☐ Kidney/Bladder ☐ Urinary Incontinence

☐ Cancer ☐ Prostate Problems

Other Comments: ______________________________

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Genitourinary (Female):

Gynecologic Problems:

- ☐ N/A
- ☐ Frequent UTI
- ☐ Difficulty Conceiving
- ☐ C-section Pregnancies
- ☐ Miscarriage
- ☐ Fecal Incontinence
- ☐ Extrautering Pregnancies
- ☐ Urinary Incontinence
- ☐ Ovarian Cyst
- ☐ Fibroids/Tumors in Uterus

Other Comments: ____________________

Menstrual Disorders:

- ☐ Painful Periods
- ☐ Heavy Periods
- ☐ Absence of Period
- ☐ Post Menopausal

Other Comments: ____________________

GYN Surgery:

- ☐ Cancer
- ☐ Kidney/Bladder
- ☐ Tubal Litigation
- ☐ Fibroids
- ☐ Oophorectomy
- ☐ Total Abdominal Hysterectomy

Other Comments: ____________________

Integumentary:

- ☐ History of Cellulitis
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Brittle Nails

Anticoagulation Tx:

- ☐ Aspirin
- ☐ Coumadin
- ☐ Other

Coagulation Disorder:

- ☐ Yes
- ☐ No

Other Comments: ____________________

History Taken By: ____________________

Reviewed By: ____________________