PATIENT INFORMATION FORM

Optimal Wellness Center, 172 Franklin Ave Suite 4A, Ridgewood NJ 07450

Patient Name: (Last)_________________________(First)_________________________(MI)___

Name you prefer to be called: ____

Address: ____

City: ______________________________________ State: ______ Zip: ______________

Home Phone: __________________ Cell Phone: ___________________

Birthdate: _____________________ Age: _______

Email Address: _____________________________ Social Security Number: _______________

Sex: Male Female Transgender (F to M) (M to F) Gender queer Choose not to disclose

Other gender category not listed

Marital Status: Single Married Domestic Partnership Divorced Separated Widowed

Employment Status: Full-time Part-time Unemployed Disabled Retired Military

Employment Information Employer: _____________________ Occupation: ___________________

Employer Address: ____

City: ______________________________________ State: ______ Zip: ______________

Work Phone: ___________________ Ext: ________

Emergency Contact

Name: ______________________________ Relationship: ____________ Phone: ___________

Primary Care Provider: ____ Phone: ___________

Pharmacy and Labs

Preferred Pharmacy: ____

Address: ____ Phone: ___________

Preferred Lab: ____

Address: ____ Phone: ___________

Insurance

Primary Insurance: _______________________________________

Secondary Insurance: _____________________________________

Please present your insurance card to staff at the front desk.

How did you hear about our office?____

Referred by______________________ Other_____________________

____ ______________________________

Signature Date

____

Printed Name

PLEASE COMPLETE, PRINT, AND BRING PRINTED FORM WITH YOU

New Patient Medical History Form

Name: (First)______________________________ (Last))______________________________ (MI)____
Date of Birth: _____/_____/__________ Date of Visit: _____/_____/__________
Phone (Home/Cell)__________________________ (Work)__________________________ Gender: M / F
Referred By:______________________________

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
   Explain a "no" answer:____
   ____
2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?:____
   ____
3. Are you taking any medications at the present time? Yes No

Current Medications
(List Current Prescriptions)

1.________________________ Dose:_____________________ Time/Day:_____________________
2.________________________ Dose:_____________________ Time/Day:_____________________
3.________________________ Dose:_____________________ Time/Day:_____________________
4.________________________ Dose:_____________________ Time/Day:_____________________
5.________________________ Dose:_____________________ Time/Day:_____________________
6.________________________ Dose:_____________________ Time/Day:_____________________
7.________________________ Dose:_____________________ Time/Day:_____________________
8.________________________ Dose:_____________________ Time/Day:_____________________
9.________________________ Dose:_____________________ Time/Day:_____________________
10._______________________ Dose:_____________________ Time/Day:_____________________

Please list any Dietary Supplements, Herbs, or Vitamins you are currently taking:

1.____________________ 2.____________________ 3.____________________ 4.____________________

Medical Allergies

Medication Name/ Reaction

1.____ 2.____

3.____ Food Allergies:______________________________

Are you allergic to:
☐ Cocoa ☐ Soy
☐ Milk Protein ☐ Eggs
☐ Corn

System Review:
(Check all that apply)
☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds

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- ☐ Acne
- ☐ Snoring
- ☐ Difficulty breathing when flat
- ☐ Swelling ankles/ extremities
- ☐ Constipation
- ☐ Dysphagia/ difficulty swallowing
- ☐ Increased appetite
- ☐ Gas and bloating
- ☐ Nighttime urination
- ☐ Back pain (upper)
- ☐ Muscle aches/pain
- ☐ Seizures
- ☐ Depression
- ☐ Inability to concentrate
- ☐ Loss of interest
- ☐ Hair Changes
- ☐ Fatigue/ tiredness
- ☐ Skin rash
- ☐ Shortness of breath
- ☐ Fainting/Blacking out
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Indigestion
- ☐ Decreased appetite
- ☐ Urinary frequency/ urgency
- ☐ Loss of urine control
- ☐ Back pain (lower)
- ☐ Dizziness
- ☐ Weakness/ low energy
- ☐ Insomnia
- ☐ Mood changes
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Cough
- ☐ Chest pain
- ☐ Palpitations
- ☐ Bloating
- ☐ Food intolerance
- ☐ Nausea/ vomiting
- ☐ Heartburn
- ☐ Slow urine flow
- ☐ Blood in stools
- ☐ Joint pain
- ☐ Headaches
- ☐ Anxiety
- ☐ Memory loss
- ☐ Nervousness
- ☐ Excessive sweating
- ☐ Blood clots

(Men only)

- ☐ Loss of interest in sex
- ☐ Low testosterone

(Women only)

- ☐ Absence of periods
- ☐ Abnormal/excessive menstruation
- ☐ Difficulty getting pregnant
- ☐ Hot Flashes
- ☐ Facial hair
- ☐ Change in bladder habits
- ☐ Loss of interest in sex

Past & Current Medical Diagnosis (check all that apply)

- ☐ High Blood Pressure *
- ☐ Heart Valve Disease
- ☐ Heart Attack (Date):_____________*
- ☐ Coronary Artery Disease
- ☐ High Cholesterol
- ☐ Kidney Disease *
- ☐ Arthritis
- ☐ Depression
- ☐ Diabetes Mellitus Type 2
- ☐ Arrhythmia
- ☐ Lung Disease
- ☐ Diabetes Mellitus Type 1 *
- ☐ Congestive Heart Failure
- ☐ Liver Disease *
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anxiety
- ☐ Reflux Disease/ GERD *
- ☐ Obstructive Sleep Apnea
- ☐ Bleeding Tendencies
- ☐ Polycystic Ovarian Disease
- ☐ Psychologically hospitalized Date:____________________
- ☐ Pneumonia
- ☐ Asthma
- ☐ Eating Disorder
- ☐ Psychiatric Illness *
- ☐ Depression
- ☐ Glaucoma
- ☐ Migraines
- ☐ Seizures
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

- ☐ Peptic Ulcer Disease
- ☐ Taking Steroids Lithium Phenothiazine
- ☐ Infertility
- ☐ Anemia
- ☐ Bone Fractures*
- ☐ Inflammatory Bowel Disease*

- ☐ Cancer Type____________________
- ☐ Alcohol Abuse
- ☐ Drug Abuse

Past Medications

		Yes	No
1)	Steroids	Yes	No
2)	Lithium	Yes	No
3)	Phenothiazines	Yes	No

4) Other _____________________________

____

____

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Gynecological History

Pregnancies: Number:_______________ Dates/ Age:____
Natural Delivery or C-Section (specify) :____
Menstrual: Onset: ____________________ ☐ Are you pregnant
Duration: __________________ ☐ Planning on becoming pregnant in the next six months
Are they regular: Yes No
Pain associated: Yes No
Last menstrual period:____

Hormone Replacement Therapy: Yes No
What:____
Birth Control Pills: Yes No
Type:____
Last Check Up:____

Previous Medical Testing

Have you had any recent labs done? Yes or No. If yes, Date: ____________ and location_____________

EKG Date: _________ Doctor: __________________ Results: __________________

Sleep Study Date: ____________ Doctor: _____________________ C-pap? Yes No

Test	Date	Doctor	Results
Heart Stress test	Date: _________	Doctor: __________________	Results: __________________
Heart Catheterization	Date: _________	Doctor: __________________	Results: __________________
Breathing (Test PFT's)	Date: _________	Doctor: __________________	Results: __________________
Upper Endoscopy (EGD)	Date: _________	Doctor: __________________	Results: __________________
Colonoscopy	Date: _________	Doctor: __________________	Results: __________________
Ultrasound or Gallbladder	Date: _________	Doctor: __________________	Results: __________________
DEXA Scan	Date: _________	Doctor: __________________	Results: __________________
Mammogram	Date: _________	Doctor: __________________	Results: __________________
Pap & Pelvic exam (woman)	Date: _________	Doctor: __________________	Results: __________________
Prostate exam (men)	Date: _________	Doctor: __________________	Results: __________________

Prior Surgeries/ Hospitalizations

Type: ____ Date of Operation: __________________
Type: ____ Date of Operation: __________________
Type: ____ Date of Operation: __________________
Type: ____ Date of Operation: __________________
Type: ____ Date of Operation: __________________

Have you ever had prior **Bariatric Surgery?** If YES please list the type of operation/ date performed.

Type: ____ Date of Operation: __________________

Name of Surgeon____ Facility: ____________________________

Family Medical History
(Describe Medical diagnosis, Weight History)

Father: ☐Alive or ☐Deceased (age_____) Medical Problem(s):_________________ Overweight: Y / N

Mother: ☐Alive or ☐Deceased (age_____) Medical Problem(s):_________________ Overweight: Y / N

Siblings:# Brothers _____ # Sisters____ Medical Problem(s):_________________ Overweight: Y / N

Children: # Children_____ Medical Problem(s):_________________ Overweight: Y / N

Has any blood relatives ever had any of the following:

Glaucoma	Yes	No	Who: ___________________________
Asthma	Yes	No	Who: ___________________________
Epilepsy	Yes	No	Who: ___________________________
High Blood Pressure	Yes	No	Who: ___________________________
Kidney Disease	Yes	No	Who: ___________________________
Diabetes	Yes	No	Who: ___________________________
Psychiatric Disorder	Yes	No	Who: ___________________________
Heart Disease/ Stroke	Yes	No	Who: ___________________________

How does your weight affect your life and health? ____

____

____

1. Present Weight:___________ Height (no shoes): :___________ Desired Weight:
2. In what time frame would you like to be at your desired weight? :______________________

Weight History

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago?________

As best as you can remember, how much did you weigh one year ago?________

Five years ago?________ Ten years ago?________

3. Birth weight: ________ Weight at 20 years of age: ________ Weight one year ago: ________
4. What is the main reason for your decision to lose weight? 1)____________________________
   2)
   3)
   4)
   5)
5. When did you begin gaining excess weight? (Give reasons, if known):______________________
   ____
6. What has been your maximum lifetime weight (non-pregnant) and when?__________________
   ____

Triggers for your weight gain (check all that apply):

☐ Stress ☐ Marriage ☐ Divorce ☐ Illness
☐ Medication abuse ☐ Travel ☐ Injury ☐ Nightshift work
☐ Insomnia ☐ Quitting (circle all that apply): Smoking/ Alcohol/ Drugs

Previous weight loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone Diet ☐ Medifast ☐ Dash Diet ☐ Paleo Diet
☐ HCG Diet ☐ Ornish Diet ☐ Mediterranean Diet
☐ Other:_____________________

What was your maximum weight loss?____

What was your greatest challenges with dieting?____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
☐ Other:______________________

What worked? ____
What didn't work? ____
Why or why not? ____

Lifestyle History

How often do you eat breakfast?______ days per week at _____ : _____ a.m.
Number of times you eat per day:______
Do you get up at night to eat? Y / N If so, how often? ______ times
Daily servings of: Vegetables ______ Fruits ______ Meat ______ Dairy ______

Sweet beverages (check all that apply)
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/ tea If so, how many times per day__________

Number of times per week you eat fast food: Breakfast______ Lunch______ Dinner ______

Of the following check all the items that you feel help explain or describe your eating habits:

☐ Thinking about food too much of the time	☐ Eating to take my mind off other problems
☐ Eating high-fat foods	☐ Not paying attention to what I'm eating
☐ Eating too many sweet foods	☐ Overeating at social events
☐ Eating too quickly	☐ Lack of satisfaction in life
☐ Uncontrollable binges	☐ Eating in reaction to boredom
☐ Eating in reaction to tension and depression	☐ Other (explain)__________________________
☐ Overeating when alone	
☐ Using food as a reward	

Eating triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties
☐ Eating Out ☐ Fast Food ☐ Other: ____

1. Is your spouse, finance or partner overweight Yes No
2. By how much is he or she overweight? ______________________________________
3. How often do you eat out? ____
4. What restaurants do you frequent? ____
5. How often do you eat "fast foods?" ____
6. Who plans meals? ________________ Cooks? ________________ Shops? ________________
7. Do you use a shopping list? Yes No
8. What time of day and on what day do you usually shop for groceries? ______________________
9. Food(s) you dislike: ____

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions

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10. Food(s) you crave: ____
11. Favorite foods: ____
12. Any specific time of the day or month do you crave food? ______________________
13. Do you drink coffee or tea? Yes No How much daily?____________________
14. Do you drink cola drinks? Yes No How much daily?____________________
Diet Regular
15. Do you use a sugar substitute? ___________ Butter? ___________ Margarine? ___________
16. Do you wake up hungry during the night? Yes No
What do you do? ____
17. What are your worst food habits? ______________________________________
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?
Explain: ____
____
20. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:
____
____
21. Exercise type: ____
Duration:_____ Hours:_____ Minutes:_____ Number of times per week:_____
What prevents you from exercising? ______________________________________
How many hours do you sleep per night?____
How many times do you get up during the night? ___ Do you feel rested In the morning?_____

Social History

Smoking:	☐ Never	☐ Current smoker (_____packs/day)	☐ Past smoker (quit_____ years ago)
Alcohol:	☐ Never	☐ Occasional	☐ Regularly (_____ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs:	☐ Never	☐ Current	☐ Past	☐ Types of drugs ________________
Marijuana	☐ Never	☐ Current user (_____ times/day)		

22. Typical Breakfast | Typical Lunch | Typical Dinner

Typical Breakfast	Typical Lunch	Typical Dinner
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________
Time eaten:____________	Time eaten:____________	Time eaten:____________
Where:_______________	Where:_______________	Where:_______________
With whom:____________	With whom:____________	With whom:____________

23. Describe your usual energy level: ______________________________________
24. Behavior style: (answer only one)
___You are always calm and easy going.
___You are usually calm and easy going.
___You are sometimes calm with frequent impatience.
___You are seldom calm and persistently driving for advancement.
___You are never calm and have overwhelming ambition.
___You are unable to relax
25. Please describe your general health goals and improvements you wish to take: _____________
____
____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.