



## NEW PATIENT INFORMATION

Name	_____	Date of Birth	_____
Address	_____ _____	SS #	_____
Home Phone	_____	Marital Status (circle)	S M D W
Work Phone	_____	Cell Phone	_____
Employer	_____	E-Mail	_____
Address	_____ _____	Driver's License #	_____
		Occupation	_____
		Phone	_____ Ext _____

---

---

Insurance	_____			
ID #	_____			
Policy/Group #	_____			
Primary Physician	_____	Phone _____		
Address:	_____ _____	Fax _____		
Principal Insurance Holder	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Partner	<input type="checkbox"/> _____
Name	_____	Phone	_____	

---

---

Emergency Contact					
Name	_____	Phone	_____		
Address	_____ _____				
Relationship	<input type="checkbox"/> Spouse	<input type="checkbox"/> Partner	<input type="checkbox"/> Parent	<input type="checkbox"/> Friend	<input type="checkbox"/> _____

I understand that I am financially responsible for all charges incurred by me. I hereby authorize payment directly to Paul B. Wizman, M.D. for the medical and/or surgical benefits, if any, otherwise payable to me under the terms of my insurance. I hereby authorize Paul B. Wizman, M.D. to release any information acquired in the course of my treatment or examination. I hereby authorize any physician, hospital or medical facility to provide all information regarding my medical history and treatment to Paul B. Wizman, M.D. I hereby authorize any photocopies of this form to be as valid as the original.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_



# MEDICAL & DIETARY HISTORY QUESTIONNAIRE

Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_  
 Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 (To be filled out by RN) Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

### Weight Related Illnesses

- Asthma Year diagnosed \_\_\_\_\_
- Depression Year diagnosed \_\_\_\_\_ Medications \_\_\_\_\_
- Diabetes Year diagnosed \_\_\_\_\_  
 Controlled with:  Diet  Insulin  Oral meds  
 Blood sugars taken \_\_\_\_\_ times daily  
 Last reading \_\_\_\_\_
- High Blood Pressure Year diagnosed \_\_\_\_\_ Medications \_\_\_\_\_ Diet \_\_\_\_\_
- High Cholesterol Year diagnosed \_\_\_\_\_ Medications \_\_\_\_\_
- Heart Disease Year diagnosed \_\_\_\_\_  
 Angina  M.I./CABG  Abnormal EKG or Stress Test  Palpitations
- Shortness of breath  At rest  With minimal exertion  With moderate exertion
- Sleep Apnea Syndrome Year diagnosed \_\_\_\_\_  
 Sleep study  C-Pap used  Morning headaches
- Symptoms of Sleep Apnea  
 Restless sleep  Snoring  Frequent awakenings  
 Observed apnea  Daytime drowsiness episodes  Coughing/choking at night
- Hiatal Hernia
- GERD (Gastro Esophageal Reflux Disease) Year diagnosed \_\_\_\_\_  
 Symptoms of GERD  Heartburn  Belching and/or sour fluid in back of throat
- Gallbladder Disease Year diagnosed \_\_\_\_\_
- Leakage or urine with laugh/cough/sneeze
- Low back pain Seen by physician \_\_\_\_\_  
 Pain/anti-inflammatory medication How many times per week \_\_\_\_\_
- Pain in  Hips  Knees  Ankles  Feet  
 Seen by physician \_\_\_\_\_  Pain/anti-inflammatory medication - Times per week \_\_\_\_\_
- Excessive heavy painful periods  Infertility



Name \_\_\_\_\_

Date \_\_\_\_\_

### DIET AND WEIGHT LOSS HISTORY

Current Weight _____	Height _____	BMI _____
Weight 1 year ago _____	Age you became morbidly obese _____	
Are you at your highest weight ever? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If you answered no, what was your highest weight and when?		
_____ Lbs	___/___/___	
Eating Habits	<input type="checkbox"/> Binge	<input type="checkbox"/> Stress <input type="checkbox"/> Boredom <input type="checkbox"/> Loneliness

Please check all previous weight loss methods that you have tried. Include both month and year.

<b>◆ Commercial Diet Programs</b>			
<input type="checkbox"/> Weight Watchers	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Diet Workshop	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Jenny Craig	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> OA	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> TOPS	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Nutrisystem	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Other _____	How Long _____	From ___/___ To ___/___	Lbs Lost _____

<b>◆ Prescription Diet Medications</b>			
<input type="checkbox"/> Redux (dexfenfluramine)	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Pondimin (fenfluramine)	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Fen-Phen	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Phentermine/Fastin/Adipex	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Amphetamines	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Meridia (sibutramine)	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Xenical (orlistat)	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Other _____	How Long _____	From ___/___ To ___/___	Lbs Lost _____

<b>◆ Liquid Diets</b>			
<input type="checkbox"/> Optifast	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> HMR	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Slimfast	How Long _____	From ___/___ To ___/___	Lbs Lost _____
<input type="checkbox"/> Other _____	How Long _____	From ___/___ To ___/___	Lbs Lost _____

Name \_\_\_\_\_

Date \_\_\_\_\_

**◆ Herbal & Nonprescription Remedies**

- |  |                |                         |                |
|--|----------------|-------------------------|----------------|
| <input type="checkbox"/> Ephedra, ma huang     | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> Over the Counter Aids | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| List _____                                     | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> Other _____           | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |

**◆ Therapy and Other Programs**

- |  |                |                         |                |
|--|----------------|-------------------------|----------------|
| <input type="checkbox"/> Behavior Therapy  | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> Psychotherapy     | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> Exercise Programs | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> Feeding Ourselves | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |

**◆ Self Initiated or Fad Diets**

- |                                |                |                         |                |
|--------------------------------|----------------|-------------------------|----------------|
| <input type="checkbox"/> _____ | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> _____ | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> _____ | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |
| <input type="checkbox"/> _____ | How Long _____ | From ___/___ To ___/___ | Lbs Lost _____ |

**◆ Medical and Health Care Treatments**

- |   |                              |                |
|---|------------------------------|----------------|
| <input type="checkbox"/> Previous gastric surgery, stomach stapling | What _____ Mo/Yr _____/_____ | Lbs Lost _____ |
| <input type="checkbox"/> Jaw Wiring                                 | Mo/Yr _____/_____            | Lbs Lost _____ |
| <input type="checkbox"/> Other Surgery _____                        | Mo/Yr _____/_____            | Lbs Lost _____ |
| <input type="checkbox"/> Acupuncture                                | Mo/Yr _____/_____            | Lbs Lost _____ |
| <input type="checkbox"/> Hypnosis                                   | Mo/Yr _____/_____            | Lbs Lost _____ |
| <input type="checkbox"/> Other _____                                | Mo/Yr _____/_____            | Lbs Lost _____ |

**At each age below, place a check next to the best description of how heavy you were in comparison to your peers.**

- |        |                                |                                |                                  |  |
|--------|--------------------------------|--------------------------------|----------------------------------|--|
| Age 5  | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Age 10 | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Age 15 | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Age 20 | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Age 25 | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |
| Age 30 | <input type="checkbox"/> Obese | <input type="checkbox"/> Heavy | <input type="checkbox"/> Average | <input type="checkbox"/> Below Average |

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_



Name \_\_\_\_\_

Date \_\_\_\_\_

**SURGICAL HISTORY**

List all prior surgeries and hospitalizations.

Procedure/Diagnosis	Date	Hospital
	/	
	/	
	/	
	/	
	/	
	/	
	/	
	/	

Have you ever had problems with anesthesia?       Yes  No

Have you ever had a hernia?       Yes  No    What type? \_\_\_\_\_

Do you currently have a hernia?       Yes  No    What type? \_\_\_\_\_

**MEDICATIONS**

List all medications, vitamins and herbal supplements you are currently taking. Please take the information directly from the prescription bottle.

Medication	Dosage	Time Taken	Used to Treat



Name \_\_\_\_\_

Date \_\_\_\_\_

**ALLERGIES**

List all allergies to medications.

Medication	Reaction

List all food allergies.

Medication	Reaction

Do you have an allergy to any latex products?       Yes  No

If yes, what have you experienced? \_\_\_\_\_

Do you have an allergic reaction to tape?       Yes  No

**SOCIAL HISTORY**

Do you smoke?                       Yes  No                      How many packs per day? \_\_\_\_\_  
For how long? \_\_\_\_\_

Have you quit smoking?            Yes  No                      How long ago? \_\_\_\_\_

Do you use alcohol?                 Yes  No                      How often? \_\_\_\_\_

Do you use recreational drugs?    Yes  No                      What kind? \_\_\_\_\_  
How often? \_\_\_\_\_

Have you taken any extended car or plane trips within the last 3 months?    Yes  No

Are you planning an extended car or plane trip within the next 3 months?    Yes  No

Name \_\_\_\_\_

Date \_\_\_\_\_

## FAMILY MEDICAL HISTORY

### Father

- Living       Deceased      Cause of Death \_\_\_\_\_ Age \_\_\_\_\_  
 History of       Obesity       Heart Disease       Hypertension       Diabetes  
 Cancer      If yes, what kind \_\_\_\_\_

### Mother

- Living       Deceased      Cause of Death \_\_\_\_\_ Age \_\_\_\_\_  
 History of       Obesity       Heart Disease       Hypertension       Diabetes  
 Cancer      If yes, what kind \_\_\_\_\_

### Brothers

- Living       Deceased      Cause of Death \_\_\_\_\_ Age \_\_\_\_\_  
 History of       Obesity       Heart Disease       Hypertension       Diabetes  
 Cancer      If yes, what kind \_\_\_\_\_

### Sisters

- Living       Deceased      Cause of Death \_\_\_\_\_ Age \_\_\_\_\_  
 History of       Obesity       Heart Disease       Hypertension       Diabetes  
 Cancer      If yes, what kind \_\_\_\_\_

## REVIEW OF SYSTEMS

### Head, Ears, Nose and Throat

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Stuffy Nose   | <input type="checkbox"/> Haloes Around Lights | <input type="checkbox"/> Loss of Balance      |
| <input type="checkbox"/> Runny Nose    | <input type="checkbox"/> Loss of Night Vision | <input type="checkbox"/> Sore Throat          |
| <input type="checkbox"/> Hay Fever     | <input type="checkbox"/> Buzzing in Ears      | <input type="checkbox"/> Lump in Throat       |
| <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Ringing in Ears      | <input type="checkbox"/> Trouble Swallowing   |
| <input type="checkbox"/> Earache       | <input type="checkbox"/> Discharge from Ears  | <input type="checkbox"/> Pain with Swallowing |
| <input type="checkbox"/> Headache      | <input type="checkbox"/> Loss of Hearing      | <input type="checkbox"/> Hoarseness           |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Double Vision        |
| <input type="checkbox"/> Vertigo       |   |   |

### Respiratory

- |  |  |                                    |
|--|--|------------------------------------|
| <input type="checkbox"/> Cough           | <input type="checkbox"/> Blood in Sputum                   | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> Wheezing        | <input type="checkbox"/> Breathlessness with Exertion      | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Use Two Pillows | <input type="checkbox"/> Wake up at Night Short of Breath  |                                    |
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Wake up at Night Coughing/Choking |                                    |

Name \_\_\_\_\_

Date \_\_\_\_\_

### Cardiovascular

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Palpitations          | <input type="checkbox"/> Squeezing of Chest  | <input type="checkbox"/> Cold Feet               |
| <input type="checkbox"/> Pounding of the Heart | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blue Toes               |
| <input type="checkbox"/> Skipping of Heartbeat | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> History of Blood Clots  |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Abnormal EKG        | <input type="checkbox"/> Calf Pain After Walking |
| <input type="checkbox"/> Numbness in Arm       | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Loss of Pulses          |
| <input type="checkbox"/> Previous Heart Attack |  |  |

### Gastrointestinal

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Heartburn              | <input type="checkbox"/> Stomach Pain             | <input type="checkbox"/> Hemorrhoids     |
| <input type="checkbox"/> Nausea                 | <input type="checkbox"/> Burning in Stomach       | <input type="checkbox"/> Fissures        |
| <input type="checkbox"/> Vomiting               | <input type="checkbox"/> Blood in Stool           | <input type="checkbox"/> Cramps          |
| <input type="checkbox"/> Belching               | <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Gassiness       |
| <input type="checkbox"/> Fluid in Throat        | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Irritable Colon |
| <input type="checkbox"/> Burning in Throat      | <input type="checkbox"/> Pain with Bowel Movement | <input type="checkbox"/> Colitis         |
| <input type="checkbox"/> Food Sticking in Chest |   |  |

### Urinary

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Pain with Urination    | <input type="checkbox"/> Frequent Urination      | <input type="checkbox"/> Kidney Stones  |
| <input type="checkbox"/> Trouble Starting Urine | <input type="checkbox"/> Nighttime Urination     | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Trouble Stopping Urine | <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Nephritis      |
| <input type="checkbox"/> Leakage of Urine       | <input type="checkbox"/> Bladder Stones          |   |
| <input type="checkbox"/> Small Urine Stream     | <input type="checkbox"/> Blood in Urine          |   |

### OB/GYN

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you have excessively heavy periods?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have break-through bleeding?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have painful periods?                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you had difficulty conceiving in the past?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you currently have problems with infertility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you suffered with excess body hair or acne? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been diagnosed with polycystic ovaries? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking hormones?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking birth control pills?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of last mammogram                           | ___/___/___                  |                             |
| Date of last PAP smear                           | ___/___/___                  |                             |

Name \_\_\_\_\_

Date \_\_\_\_\_

### Musculo-Skeletal

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Ankle Pain        | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Knee Pain         | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Left <input type="checkbox"/> Right |
| <input type="checkbox"/> Disc Disease         | <input type="checkbox"/> Back Pain         |  |

### Endocrinology

- Diabetes
- |   |            |
|---|------------|
| <input type="checkbox"/> Adult Onset        | Date _____ |
| <input type="checkbox"/> Insulin Dependent  | Date _____ |
| <input type="checkbox"/> Oral Hypoglycemics | Date _____ |

### Neurological

- Stroke (Cerebro-vascular accident)
- |  |                                |                               |
|--|--------------------------------|-------------------------------|
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Hands | <input type="checkbox"/> Feet |
| <input type="checkbox"/> Weakness          | <input type="checkbox"/> Hands | <input type="checkbox"/> Feet |
- Seizures  
 Epilepsy  
 Pseudotumor Cerebri

### Psychological

- |  |  |  |                                  |
|--|--|--|----------------------------------|
| <input type="checkbox"/> Depression    | <input type="checkbox"/> Bi-polar Disorder | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> OCD     |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Suicide Attempt   | <input type="checkbox"/> Anorexia        | <input type="checkbox"/> Bulimia |

### Skin

- |                                     |                                     |                                |
|-------------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Urticaria  | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Rashes     | <input type="checkbox"/> Open Sores |                                |

### Hematology

- |   |                                  |   |
|---|----------------------------------|---|
| <input type="checkbox"/> Anemia                     | <input type="checkbox"/> Heparin | <input type="checkbox"/> Iron Supplements |
| <input type="checkbox"/> Previous Blood Transfusion |                                  | Date _____                                |
| Reason _____  |                                  |   |

- ◆ Would you refuse blood products?  Yes  No  
Reason \_\_\_\_\_



Name \_\_\_\_\_

Date \_\_\_\_\_

**Infectious Diseases**

- HIV
- Liver Disease
  - Hepatitis  A  B  C
  - Cirrhosis
- Auto Immune Disorder
  - Lupus
  - Guillain-Barre Syndrome
  - Other \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_