Boone Hospital Center

BHC MSWL Program Registration Form

Date ______________________

Last name | First name | Middle Initial | Date of birth | Age

Address: ________________________________City: _____________________________ State/Zip: ______________

Sex: M / F / Non-Binary   Social Security # ________________________ Hispanic Ethnicity: Yes or No

Race: White / Black / American Indian or Alaska Native / Native Hawaiian or Other Pacific Islander / Asian / Other: __________

Religion: _______________________________________Email Address:____

Home Phone #: ________________________________ Work Phone #: _______________________________________

Cell Phone #: ____

Which is the best number to reach you during the day? _____________________   May we call you at work?   Yes / No

Emergency Contact Name: ___________________________________ Relationship: _____________________________

Address/phone number: ____

Height: _______Weight:_______   BMI:_______

Marital Status: ❒ Married ❒ Single ❒ Widowed ❒ Divorced ❒ Partnered
For how long? ____________

Highest Education Level: ❒ Grade School ❒ High School/GED ❒ Vocational Tech ❒ College ❒ Post-Graduate

Are you currently employed? ❒ No ❒ Yes, occupation: ____

❒ Full-time ❒ Part-time ❒ Volunteer

How long have you been employed? _________ Years, __________ months

Employer Name: ____

Employer Phone Number: ____

What level of activity does your job involve?
❒ Little (sedentary)
❒ Moderately active
❒ Very active (laboring, etc.)

How did you hear about our program?
❒ Doctor (who) ______________________________ ❒ TV
❒ Radio (what one) ___________________________ ❒ Word of mouth
❒ Newspaper (which one) ____
❒ Internet (which site) ____
❒ Other (please specify) ____

Primary Health Care Physician - please provide information about your primary doctor below:

Name Phone Number

Address City State Zip

Referring Physician – please provide information about the doctor who referred you, **if different** than your primary doctor

Name Phone Number

Address City State Zip

NEW PATIENT MEDICAL HISTORY FORM

How does your weight affect your life and health?

____

____

____

Weight History

When did you first notice that you were gaining weight?

Childhood ___ Teens___ Adulthood____ Pregnancy___ Menopause__

Did you ever gain more than 20 pounds in less than 3 months? YES____ NO____

If so, when?____

How much did you weigh?

One year ago?_____ Five years ago?______ 10 years ago?______

Life events associated with weight gain (check all that apply):

Marriage___ Divorce___ Pregnancy___ Job Change__
Illness___ Travel____ Injury____ Nightshift work___
Abuse___ Alcohol___ Drugs___ Quit Smoking__
Medication (please list: ____)

Previous Weight-loss programs (check all that apply):

Weight watchers____ Atkins______ Zone Diet ___ Medifast____
Nutrisystem_____ Paleo Diet____ HCG Diet____ South Beach ___
Jenny Craig____ Dash Diet___ Ornish Diet___ Mediterranean___
LA Weight Loss___ Other:______________________________

What was your maximum weight loss?____________________

What are 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: (including supplements) ____

What worked? ____

What didn't work? ____

Why or why not? ____

Nutritional History

How often do you eat breakfast? _____ days per week at ____:____am.

Number of times you eat per day: _____ times per day.

What beverages do you drink? _______________________________________

Do you get up to eat at night? YES___ NO ____ if so, how often? ________times.

List any food intolerances/ restrictions: _______________________________

Food Triggers (check all that apply):

Stress____	Boredom___	Anger____	Insomnia____
Parties____	Eating out____	Seeking reward____	Other______________________

Food Cravings: (check all that apply):

Sugar___	Chocolate____	Starches____	Salty____
High fat____	Fast food____	Large Portions____	

Favorite foods: ____

Medical History

Exercise type: ____

Duration: ____ hours _____ minutes Number of times per week:______

Does anything limit your form exercising: ______________________________________

____

How many hours do you sleep per night? ____ hours per night.

Do you feel rested in the morning? ___________________________

Past medical history (check all that apply):

Heart attack___ Angina___ Gallbladder stones___ Sleep apnea____
High blood pressure____ Stroke___ indigestion/reflux___ Thyroid_____
High cholesterol ____ Diabetes___ Celiac disease____ Anxiety _____
High Triglycerides____ Gout____ Pancreatitis ____ Depression____
Infertility ____ Arthritis____ Bipolar___ Seizures____
Glaucoma____ Kidney stones____ Polycystic Ovarian syndrome___
Cancer (type/s):____

Have you ever been diagnosed with an eating disorder? Yes/ NO

If yes, which one? ____

Past Surgical History (check all that apply):

Gastric bypass____ Gastric Banding_____ Gastric Sleeve_____

Gallbladder_____ Heart bypass_____ Hysterectomy______

Other:____

Medications: (list all current medication, including OTC, supplements and herbs):

________________ ________________ ________________ __________________

________________ ________________ ________________ __________________

________________ ________________ ________________ __________________

________________ ________________ ________________ __________________

Allergies:

Medication: ____

Food: ____

Social History

Smoking: Never___ Current smoker (____ packs/ day) Past smoker (quit ____ years ago)

Alcohol: Never___ Occasional____ Regularly (_____ drinks per day)

Prior treatment for alcoholism? YES/ NO

Drugs: Never____ Current____ Past ____ Type of drugs:_____________________

Marijuana: Never____ Current User (____ times/ day)

Family History

Obesity (check all that apply):

Mother___ Father____ Sister____ Brother____ Daughter____ Son_____

Diabetes (check all that apply):

Mother___ Father____ Sister____ Brother____ Daughter____ Son_____

Other (check all that apply):

High blood pressure____ Heart disease____ High cholesterol____
High triglycerides ____ Anxiety ____ Thyroid Problems____
Bipolar disorder ____ Stroke____ Depression ____
Alcoholism ____ Cancer (type/s):______________________________

Other:____

Gynecologic History

Age periods started? _________ age periods ended _________

Periods are: Regular / Irregular Heavy / Normal / Light

Number of Pregnancy: _____ Number of children: ______
Age of first pregnancy: _____ Age of last pregnancy: _____

System Review (check all that apply):

Recent weight loss more than 10 pounds ___ Recent weight gain more than 10 pounds_____
Acne___ Skin rash_____ Cough_____
Snoring___ Shortness of breath____ Chest Pain____
Fainting/ Blacking out___ Palpitations____ Difficulty breathing when flat____
Bloating____ Abdominal pain____ Swelling ankles/ extremities____
Constipation____ Diarrhea____ Food Intolerance ____
Indigestion____ Nausea/ vomiting__ Dysphagia/ difficulty swallowing____
Heart burn____ Increased appetite____ Decreased appetite____
Slow urination_____ Urination frequency/urgency____ Gas and bloating____
Nighttime urination ____ Blood in stool ____ Back Pain (upper) ____
Back pain (lower) ____ Joint Pain ____ Muscle aches/pain____
Dizziness____ Headaches____ Seizures____
Weakness/ low energy ____ Anxiety ____ Depression____
Insomnia____ Memory Loss ____ Inability to concentrate ____
Mood changes_____ Nervousness ____ Loss of interest ____
Cold Intolerance _____ Excessive sweating _____ Hair changes_____
Heat Intolerance ____ Blood Clots ______ Fatigue/ tiredness _____

Women Only

Absence of period____ Hot Flashes_____ Change in bladder habits _____
Abnormal/ excessive menstruation_____ Facial hair _____

Comments: ____

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