Boone Hospital Center
BHC Non-Surgical 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: _____

_____