SIENA PROACTIVE INTERNAL MEDICINE
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Weight Management Registration

PATIENT INFORMATION			
Last Name:	First Name:	Date:	
Date of Birth: Age: ________	Gender: Male ___________________ Female ___________________		
Current Address:	City:	State:	Zip Code:
Home Phone: Is it okay to leave a message?	Work Phone: Is it okay to leave a message?	Cell Phone: Is it okay to leave a message?	
VISIT INFORMATION			
Is today's visit accident or work-related?			
How did you hear about us? (TV, Newspaper, Physician, etc.			
Pharmacy:	Store No. (if known):	Pharmacy Phone:	
Pharmacy Address:	City:	State:	Zip Code:
PLEASE CIRCLE PREFERRED TELEPHONE NUMBER ABOVE.			

Email Address:	Social Security Number:	Do you have a CHS EPIC MyChart Account?
GENERAL INFORMATION		
Language: Do you require an interpreter?	Marital Status (circle one): Single Married Divorced Widowed	Race (circle one): American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander Other White
Ethnicity (check one) Hispanic ☐ Non-Hispanic ☐ Unknown Do not wish to provide ☐		
Are you a U.S. Veteran?	Do you work for Catholic Health Services of Long Island (CHSLI)?	Do you have relatives that work for CHSLI?

PRIMARY CARE PROVIDER INFORMATION			
Who was your previous primary care physician?			
PATIENT RELATIONSHIPS / EMERGENCY CONTACT INFORMATION			
Emergency Contact Name:	Phone:	Relationship to you:	
Address:	City	State	Zip code:
EMPLOYMENT INFORMATION			
Employment Status (circle one): Full-Time, Part-Time, Student, Retired, Unemployed Occupation:	Employer Name and Address:		
Employer Phone:	Employer Fax	Email:	
INSURANCE INFORMATION			
Primary Insurance:	Group No.:	Secondary Insurance:	Group No:
Patient Relationship to Subscriber (check one):		Patient Relationship to Subscriber (check one):	
Subscriber ID:		Subscriber ID:	
Subscriber Name:	Date of Birth:	Subscriber Name:	Date of Birth:
Subscriber Address:	SSN:	Subscriber Address:	SSN:
POLICY HOLDER EMPLOYMENT INFORMATION (POLICY HOLDER) **Note: If you are the policy holder, skip this section.**			
Employer	Employment Status: (circle): F/T P/T, Student, Retired, Unemployed	Date of Retirement:	
Employer Address:	City:	State:	Zip Code:
Employer Phone:	Employer Fax:	Email:	
GUARANTOR INFORMATION			
Guarantor Name:	Date of Birth	Social Security No.:	Phone
Guarantor Address:	City:	State:	Zip Code::
Phone:	Fax:	Email:	

ALLERGIES

Medication Allergies:

Food Allergies:

Are you allergic to Latex, Shellfish or Iodine? Which one(s)?

MEDICATIONS

Medication / Supplements / Vitamins	Dose	Frequency

WOMEN ONLY

Are you pregnant / breast feeding?	How many pregnancies have you had?
Are you planning on getting pregnant?	How many live births have you had?
Last menstrual period?	Have you had irregular menses?
Difficulty becoming pregnant?	Do you have excess hair growth?

MEDICAL HISTORY
Check all that apply.

Heart Disease		Stomach Ulcers		High blood pressure	
Liver Disease		Kidney Disease		Depression	
Shortness of Breath		Stroke		Menstrual Problems	
Low Blood Sugar		Seizure		Problems with Circulation	
Snoring		Thyroid Problems		Eating Disorders	
Loss of Sex Drive		Cancer:______________________		Sleeping Problems	
Asthma		Difficulty with Erections		Insomnia	
Emphysema		Anxiety Symptoms		Diabetes	
Abdominal Pains		High Cholesterol		Chest Pain	
Irregular Heart Beat		Heart Murmurs		Chest Pressure	
Dizziness		Back Pain		Neck Pain	
Fainting		Arm Weakness		Leg Pain	
Arm Pain		Leg Cramps			
Leg Weakness		Heartburn			

Other medical problems:

Surgical Procedures:

Approximate date:
Have you had a tonsillectomy? If so, at what age?

Have you had your wisdom teeth removed? If so, at what age?

FAMILY HISTORY

Mother's Medical History:	Living (Y/N):
Father's Medical History:	Living (Y/N):
Sibling(s) Medical History Brother(s): Sister(s):	 Living (Y/N): Living (Y/N):
Grandparent(s) Medical History Maternal: Paternal:	 Living (Y/N): Living (Y/N):

When was the last time you had a:

Complete Physical Exam:	Bone Densitometry Test:
Exercise Stress Test:	Echocardiogram:
Carotid Ultrasound:	Colonoscopy:
Mammogram:	Pap Test:

ALCOHOL USE

On average, how many total drinks per week of beer, wine or other alcoholic beverages do you take?

______ less than 1 _______ 1 - 5 ________ 6 - 10 _________ 11 - 15

______ 16 – 20 _______ greater than 20

SEXUAL ACTIVITY

Are you sexually active?

Yes ______ No ______ Not currently active ______

Have you ever been the victim of any physical, sexual or psychological abuse?

Yes ______ No _______

DRUG USE
Do you engage in recreational drug use?
If yes, how often per week?
Which of the following drugs do you use? Cocaine ________ Heroin _______ Marijuana ________ Oxycodone ________ Other? ____
Do you have a history of drug abuse?

TOBACCO USE	
Are you currently a smoker?	What year did you start smoking?
Are you a former smoker?	How many packs per day? ¼ _____ ½ _____ 1 _____ 2 ______
How many years did you / are you smoking?	

SMOKELESS TOBACCO	
Do you use smokeless tobacco? Yes _____ No _____ Never used_____	Are you a former or current smokeless tobacco user?
Do you snuff or chew tobacco?	If you quit using tobacco, when was your quit date?

TRAVEL HISTORY
Have you traveled outside the U.S. in the past 12 months? If yes, where and when?

SLEEP QUALITY	
What time do you: Wake up: ______________ Go to Sleep _____________	How many hours do you sleep? __________
Do you snore?	Have you been told that you snore?
Do you choke or gag during sleep?	Has someone seen you stop breathing while sleeping?
Do you wake up tired in the AM?	Do you wake up during the night?
Does your spouse snore?	How often?
Do you often feel like you need a nap?	For what reason?
Do you easily fall asleep while in a movie theatre?	Do you fall asleep while a passenger in a car?

WEIGHT HISTORY	
Estimate your average weight for the time frames indicated.	
____________ 15 to 20 years old	______________ 41 to 50 years old
____________ 21 to 30 years old	______________ Over 50 years old
____________ 31 to 40 years old	

DIET AND NUTRITION HISTORY (circle your answer)
How many meals do you eat in a typical day? 1 2 3 4 5 5+
How many snacks do you eat in a typical day? 1 2 3 4 5 5+
Do you skip meals? Yes / No
If yes, which ones? Breakfast Lunch Dinner
Do you plan your meals? Yes / No
Have you ever been diagnosed with an eating disorder? Yes / No
Have you ever had bulimia or anorexia? Yes / No
What are your favorite foods or type of food?
Are there any foods you will not eat?
Are there foods that you can't stop eating once you start?
How many times a week do you eat out (including take out)? _______ Breakfast _______ Lunch _______ Dinner
Are you distracted during meal times? Yes / No
Do you eat in response to: Anger? ________ Boredom? ________ Stress? __________
Do you drink sodas, juices, teas or other beverages? Regular ____ Yes _____ No Which type and how much? ____ Diet ____ Yes ____ No Which type and how much? ____
How many 8 oz. glasses of water do you drink per day? _________
How many times a day do you move your bowels? _________

DIET AND NUTRITION HISTORY					
Please rate the following from a scale of 1 to 5:					
	1 (Low)	2	3 (Medium)	4	5 (High)
Will Power:					
Self Esteem:					
Binging:					
Food Cravings:					
Sugar Cravings:					
Salt Cravings:					
Anxiety Symptoms:					
Commitment to lose weight:					

PREVIOUS DIET EXPERIENCE (Please skip if not applicable)				
How many times have you lose weight and gained it back? _____________				
Have you tried any of these diets:				
	Successful from the beginning?		Successful long term?	
	Yes	No	Yes	No
Your own diet				
Weight Watchers				
Jenny Craig				
Nutri System				
Atkins or Low Carb				
Zone Diet				
Ornish Diet or Vegetarian Diet				
South Beach Diet				
Liquid Diet (Slim Fast, Juices, etc.)				
Optifast or Medifast				
OTC diet pills (Ephedra, ALLI, etc.)				
Prescription Diet Pills				
Other:				

DAILY ROUTINES
What time do you eat: Breakfast ________ Lunch _________ Dinner ________

EXERCISE AND FITNESS			
How would you describe your daily activity level (based on your daily routine, not including scheduled exercise):			
	Very Sedentary		
	Sedentary to Moderate		
	Moderate to Heavy		
	Heavy		
How often do you exercise:			
Cardio (walking, running, biking, etc.)		**Resistance (weights, lifting, etc.)**	
	Rarely or never		Rarely or never
	1 – 2 times a week		1 – 2 times a week
	3 – 4 times a week		3 – 4 times a week
	5 or more times a week		5 or more times a week

How long have you been exercising regularly?
Please describe your exercise routing:
Have you ever worked with a personal trainer?
Do you find it hard to get motivated to work out?
Have you been restricted from exercise by a physician or other professional? If so, why?
Have you ever been treated by a chiropractor or physical therapist? Please describe:
Do you have any neck or back pains that restrict your exercise? Please describe:
Do you get any symptoms on exertion that restricts your ability to exercise? Please describe:
Do you have any leg or arm pains or weakness that restricts your exercise? Please describe:

YOUR OTHER PHYSICIANS Please include doctors' name, location (town) and telephone number.	
Allergist	
Cardiologist	
Chiropractor	
Dermatologist	
Endocrinologist	
Ear, Nose and Throat	
Gastroenterologist	
Nephrologist	
Neurologist	
Neurosurgeon	
OB/GYN	
Oncologist / Hematologist	
Ophthalmologist	
Orthopedist	
Pain Management	
Past Family Doctor / PCP / Internist	
Psychiatrist	
Psychologist	
Pulmonologist	
Rheumatologist	
Urologist	
Vascular	
Other	

___________________________ ___/____/____ ____________________________ ___/____/_____

Doctor's Signature Date Patient's Signature Date

rev 3/26/18