Name: Date of Birth:

Legacy Weight and Diabetes Institute

New Patient Information

Answering these questions will help your providers understand your health and how best to treat you.

If you need help filling out this form, clinic staff are happy to help.

GENERAL INFORMATION

TODAY'S DATE: _____

FULL LEGAL NAME				**HOME PHONE**
ADDRESS	**CITY**	**STATE**	**ZIP**	**CELL PHONE**
EMAL ADDRESS				**WORK PHONE**

SOCIAL SECURITY NUMBER	**DATE OF BIRTH**	**WHAT IS YOUR PREFERRED LANGUAGE?**
BIRTH SEX ☐ FEMALE ☐ MALE ☐ OTHER _____		**IF OTHER THAN ENGLISH, WOULD YOU LIKE AN INTERPRETER?** ☐ YES ☐ NO
WHAT GENDER DO YOU IDENTIFY AS? ☐ FEMALE ☐ MALE ☐ OTHER _____		**RACE (select all that apply)** ☐ OTHER _____ ☐ WHITE ☐ ASIAN ☐ AFRICAN AMERICAN
WHAT IS YOUR PREFERRED PRONOUN? ☐ SHE ☐ HE ☐ OTHER _____		☐ AMERICAN INDIAN ☐ ALASKA NATIVE ☐ PACIFIC ISLANDER ☐ HISPANIC/ LATINO
EMPLOYER		**OCCUPATION**

☐ FULL TIME	☐ RETIRED	☐ UNEMPLOYED	
☐ PART TIME	☐ STUDENT	☐ DISABLED --DATE STARTED _____	
HIGHEST LEVEL OF EDUCATION		☐ 6TH GRADE OR LESS	☐ SOME HIGH SCHOOL
☐ GED/ HIGH SCHOOL	☐ SOME COLLEGE	☐ COLLEGE DEGREE	☐ ADVANCED DEGREE
DO YOU HAVE ANY TROUBLE READING OR WRITING?		☐ NO	☐ YES
MARITAL STATUS	☐ MARRIED	☐ PARTNERED	☐ DIVORCED
	☐ SINGLE	☐ SEPARATED	☐ WIDOWED

WHO LIVES IN YOUR HOUSEHOLD?
EMERGENCY CONTACT NAME RELATIONSHIP PHONE NUMBER
WHO ARE YOUR PRIMARY SUPPORT PEOPLE?

Name: Date of Birth:

GENERAL INFORMATION (continued)

HEALTH CARE TEAM TO BEST COORDINATE CARE, PLEASE PROVIDE THE NAME AND NUMBER OF ALL HEALTHCARE PROVIDERS YOU SEE, INCLUDING THERAPISTS AND PSYCHIATRISTS. Please sign a release of information form for providers not with Legacy Health so we can discuss your care with them *(release of information form attached)*		
PROVIDER NAME & TYPE OF PROVIDER	**CITY**	**PHONE NUMBER**

PLEASE LIST INSURANCE INFORMATION OR ATTACH COPY OF CARD	
PRIMARY INSURANCE:	SECONDARY INSURANCE:
ADDRESS	ADDRESS
POLICY HOLDER NAME	POLICY HOLDER NAME
GROUP NUMBER	GROUP NUMBER
ID NUMBER	ID NUMBER
PHONE NUMBER	PHONE NUMBER
EMPLOYER	EMPLOYER

MEDICAL HISTORY

WEIGHT HISTORY

CURRENT WEIGHT	HIGHEST WEIGHT	DATE
CURRENT HEIGHT	LOWEST ADULT WEIGHT	DATE
WHEN WERE YOU FIRST OVERWEIGHT?		

ALLERGIES (MEDICATIONS/ FOOD/ ENVIRONMENTAL)

ALLERGY	REACTION	ALLERGY	REACTION

Name: Date of Birth:

FAMILY HISTORY ARE YOU ADOPTED? ☐ YES ☐ NO

FATHER ALIVE? ☐ YES ☐ NO	AGE AT TIME OF DEATH	CAUSE OF DEATH
HEALTH CONDITIONS:	☐ OBESITY ☐ DIABETES ☐ HEART DISEASE ☐ HIGH CHOLESTEROL	
MOTHER ALIVE? ☐ YES ☐ NO	AGE AT TIME OF DEATH	CAUSE OF DEATH
HEALTH CONDITIONS:	☐ OBESITY ☐ DIABETES ☐ HEART DISEASE ☐ HIGH CHOLESTEROL	

SURGICAL HISTORY: PLEASE LIST ALL SURGERIES YOU HAVE HAD

TYPE OF SURGERY	YEAR

IF YOU HAVE EVER HAD SURGERY FOR WEIGHT-LOSS , HEARTBURN, OR HIATAL HERNIA REPAIR:

WHAT PROCEDURE:
YEAR OF PROCEDURE:
WHERE PROCEDURE WAS PERFORMED:
WAS IT LATER REVERSED? ☐ YES ☐ NO DATE REVERSED & WHERE

SUBSTANCE USE

TOBACCO USE ☐ NEVER ☐ CURRENT ☐ FORMER		QUIT DATE:
HOW MUCH PER DAY ON AVERAGE?		HOW MANY YEARS TOTAL?
☐ STILL SMOKING/ USING TOBACCO ☐ USING E CIGARETTES		
MARIJUANA USE ☐ NEVER ☐ CURRENT ☐ FORMER		QUIT DATE:
IF YES, HOW OFTEN DO YOU USE? _____ TIMES PER DAY / WEEK / MONTH (CIRCLE ONE)		
TYPE OF USE (CIRCLE ONE): SMOKE/ EDIBLE/ CREAM/ OTHER		MEDICAL? ☐ YES ☐ NO
HAS YOUR MARIJUANA USE EVER BEEN A PROBLEM OR VERY HEAVY? ☐ YES ☐ NO		
ALCOHOL USE ☐ NEVER ☐ CURRENT ☐ FORMER		QUIT DATE:
IF YES, HOW MUCH? _____ DRINKS PER DAY / WEEK / MONTH / YEAR (CIRCLE ONE)		
HAS YOUR DRINKING EVER BEEN A PROBLEM OR VERY HEAVY? ☐ YES ☐ NO		
ILLICIT DRUG USE (COCAINE, AMPHETAMINES, HEROIN, ETC) ☐ NEVER ☐ CURRENT ☐ FORMER		
DRUGS USED?		QUIT DATE:

Name: Date of Birth:

MEDICATIONS: PLEASE LIST ALL PRESCRIPTION AND OVER THE COUNTER MEDICATIONS, VITAMINS, SUPPLEMENTS, AND HERBAL REMEDIES YOU ARE TAKING

NAME	DOSE	HOW OFTEN

LIST ANY PREVIOUS PSYCHIATRIC MEDICATIONS YOU HAVE TAKEN, AND FOR WHAT REASON

Name: Date of Birth:

REVIEW OF SYSTEMS CHECK YES TO CONDITIONS YOU HAVE A HISTORY OF

CONDITION	**YES**	**CONDITION**	**YES**
SKIN RASH OR CONDITION		ARTHRITIS	
BLEEDING PROBLEMS		JOINT REPLACEMENT	
HEART ATTACK		FIBROMYALGIA	
ANGINA OR CHEST PAINS		BACK PAIN	
CONGESTIVE HEART FAILURE		KIDNEY STONES	
HEART RHYTHM PROBLMS		URINARY INFECTIONS	
OTHER HEART CONDITION		LEAKAGE OF URINE	
BLOOD CLOT IN LEGS		IRREGULAR MENSTRAL PERIODS	
BLOOD CLOT IN LUNGS		POLYCYSTIC OVARIAN SYNDROME	
HIGH BLOOD PRESSURE		DIABETES	
EDEMA (SWELLING)		THYROID CONDITION	
LEG ULCERS		HIGH CHOLESTEROL	
SLEEP APNEA		HEADACHES OR MIGRAINES	
DO YOU USE A CPAP/BIPAP		STROKE OR TIA	
ASTHMA		EPILEPSY OR SEIZURE DISORDER	
COPD/ EMPHYSEMA		CANCER	
RECENT PNEUMONIA		DEPRESSION	
OTHER LUNG ISSUE		BIPOLAR DISORDER	
GERD (HEARTBURN OR ACID REFLUX)		ANXIETY OR PANIC DISORDER	
STOMACH ULCERS		PERSONALITY DISORDER	
LIVER PROBLEMS		PSYCHOSIS	
GALLBLADDER PROBLEMS		SUBSTANCE USE DISORDER	
COLON OR INTESTINAL PROBLEMS		OTHER	
HERNIA			

HAVE YOU EVER HAD A SLEEP STUDY? ☐ YES ☐ NO	
IF YES, LOCATION PERFORMED:	DATE:

Name: Date of Birth:

MENTAL HEALTH HISTORY

THROUGHOUT LIFE, HAVE YOU EVER SEEN A MENTAL HEALTH COUNSELOR? ☐ YES ☐ NO		
APPROXIMATE DATES/ YEARS	APPROXIMATE # OF SESSIONS	MAIN ISSUES ADDRESSED

ARE YOU CURRENTLY SEEING A MENTAL HEALTH COUNSELOR OR PSYCHIATRIST? ☐ YES ☐ NO

IF YES, PLEASE LIST WHO YOU ARE SEEING **MAKE SURE TO FILL A RELEASE OF INFORMATION FORM**

#1) NAME:

TYPE OF MENTAL HEALTH PROFESSIONAL:

☐ Psychiatrist or Psychiatric Nurse Practitioner (Prescribes Medication)

☐ Psychologist, Therapist, Counselor (Does Therapy)

#2) NAME:

TYPE OF MENTAL HEALTH PROFESSIONAL:

☐ Psychiatrist or Psychiatric Nurse Practitioner (Prescribes Medication)

☐ Psychologist, Therapist, Counselor (Does Therapy)

HAVE YOU EVER BEEN HOSPITALIZED FOR A MENTAL HEALTH/ PSYCHIATRIC REASON? ☐ YES ☐ NO

If yes, when & for how long?

HAVE YOU EVER BEEN IN DRUG OR ALCOHOL TREATMENT? ☐ YES ☐ NO

If yes, when & for how long?

DO YOU HAVE A HISTORY OF ABUSE? ☐ VERBAL/ EMOTIONAL ☐ PHYSICAL ☐ SEXUAL ☐ NONE

LEGAL HISTORY

☐ NO LEGAL PROBLEMS ☐ CIVIL SUIT ☐ DUI/ DWI

☐ MISDEMEANOR ☐ BANKRUPTCY ☐ FELONY

Name: Date of Birth:

DIETARY HISTORY

☐ Atkins	☐ Zone	☐ Calorie counting	☐ Overeaters Anonymous
☐ South Beach	☐ Blood type	☐ Increased exercise	☐ Diet pills/ medication
☐ Grapefruit	☐ Medifast/Optifast	☐ TOPS	☐ Others: _____
☐ Slim Fast	☐ LA Weight loss	☐ Weight watchers	_____
☐ Prism	☐ Herbalife	☐ Jenny Craig	_____

DO YOU EAT BREAKFAST EVERY DAY? ☐ YES ☐ NO	NUMBER OF MEALS PER DAY: NUMBER OF SNACKS PER DAY:

SERVINGS (BASED ON 8 OZ) OF THE FOLLOWING FLUIDS YOU TYPICALLY CONSUME PER DAY:

Water:	Fruit juice:	Coffee drinks (latte, mocha, etc):
Non-fat milk:	Regular soda:	Beer:
2% milk:	Diet soda:	Wine:
Whole milk:	Coffee/ tea:	Hard liquor :
Sports drink:	Other:	

MEALS PER WEEK EATEN IN A FAST FOOD RESTAURANT (include drive thru/ convenience stores)

Breakfast	Lunch	Dinner

MEALS PER WEEK EATEN IN A TRADITIONAL RESTAURANT, CAFETERIA, COFFEE SHOP

Breakfast	Lunch	Dinner

DO YOU HAVE ANY FOOD INTOLERANCES OR SPECIAL DIET NEEDS YOU FOLLOW NOW?
DO YOU HAVE ANY FOODS YOU DISLIKE AND REFUSE TO EAT?
DO YOU SNACK WHILE WATCHING TV OR ON COMPUTER

PLEASE RECALL ALL FOOD AND DRINK CONSUMED YESTERDAY INCLUDING BEST ESTIMATE OF SERVING SIZE

Breakfast:
Lunch:
Dinner:
Snacks:
Was this a typical day of eating?

BARRIERS TO HEALTHY EATING

☐ Time	☐ Social Occasions	☐ Financial	☐ Family/ Roommates
☐ Stress	☐ Emotional	☐ Other: _____	

Name: Date of Birth:

PHYSICAL ACTIVITY HISTORY

ARE YOU CURRENTLY PARTICIPATING IN ANY REGULAR PHYSICAL ACTIVITY?

If yes, what activities and how often?
If no, what prevents you from doing so?
Which activities do you most enjoy?
Are there any activities you have enjoyed in the past that you can't or don't do now?

HAS ANY HEALTHCARE PROVIDER GIVEN YOU RESTRICTIONS FOR EXERCISE/ PHYSICAL ACTIVITY?
If yes, what and why:

DO YOU LIMIT ANY ACTIVITIES BECAUSE OF PAIN?
If yes, where do you have pain?
Which activities do you limit?

ARE YOU CURRENTLY IN PHYSICAL THERAPY OR HAVE YOU RECENTLY SEEN A PHYSICAL THERAPIST?
If yes, what is being treated?

PLEASE CHECK ANY OF THE FOLLOWING ASSISTIVE DEVICES YOU USE, AND WHEN YOU USE THEM:

Device	**Inside Home**	**Outside of Home**	**Both**
Cane			
2 wheeled walker			
4 wheeled walker (with seat)			
Wheelchair			
Electric Scooter			
Other			

HAVE YOU FALLEN IN THE PAST 6 MONTHS?	YES	NO
ARE YOU AFRAID OF FALLING?	YES	NO
DO YOU REQUIRE ASSISTANCE WITH DAILY ACTIVITIES? (e.g. cooking, dressing, or mobility)	YES	NO