

Tuscaloosa Weightloss Center
Patient Information Form

Patient Name: (Last) _____ (First) _____ (MI) _____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Beeper/Cellular: _____

Birthdate: _____ Age: _____ Sex: M F

Employment Information:

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work phone No: _____ Ext. _____

Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy:

Thank you for selecting Dr. Peramsetty for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, cash, and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature

Date

Tuscaloosa Weightloss Center

Patient Medical History Form

Name: _____ Age: _____ Sex: M F

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
Explain a "no" answer: _____

2. Are you under a doctor's care at the present time? Yes No
If yes, for what? _____

3. Are you taking any medications at the present time? Yes No

Prescription Drugs: List all

Drug:

Dosage:

Over-the-Counter medications, vitamins, supplements: List all

Product

Dosage

4. Any allergies to any medications? Yes No
Please list: _____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
At what age? _____

7. History of Heart Attack or Chest Pain or other heart condition? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
Migraines? Yes No
Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. Gynecologic History:

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset: _____

Duration: _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____

Hormone Replacement Therapy: Yes No

What: _____

Birth Control Pills: Yes No

Type: _____

Last Check Up: _____

14. Serious Injuries: Yes No

Specify (list all) Date

15. Any Surgery: Yes No

Specify: (List all) Date

16. Family History:

Age	Health	Disease	Cause of Death	Overweight?
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Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____

Asthma: Yes No Who: _____

Epilepsy: Yes No Who: _____

High Blood Pressure Yes No Who: _____

Kidney Disease: Yes No Who: _____

Diabetes: Yes No Who: _____

Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent? _____
12. How often do you eat "fast foods"? _____
13. Who plans meals? _____ Cooks? _____ Shops? _____
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much daily? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you thing you are currently undergoing a stressful situation or an emotional upset? Explain:

29. Smoking Habits: **(answer only one)**

___ You have never smoked cigarettes, cigars or a pipe.

___ You quit smoking ___ years ago and have not smoked since.

___ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.

___ You smoke 20 cigarettes per day (1 pack).

___ You smoke 30 cigarettes per day (1-1/2 packs).

___ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast

Typical Lunch

Typical Dinner

Time eaten: _____
Where: _____
With whom: _____

Time eaten: _____
Where: _____
With whom: _____

Time eaten: _____
Where: _____
With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: **(answer only one)**

- Inactive—no regular physical activity with a sit-down job.
- Light activity—no organized physical activity during leisure time.
- Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..
- Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: **(answer only one)**

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.