W8LossMD

5206 HWY 5, Suite 101
Bryant, AR 72022
Phone: (501) 860-1642
W8LossMD@gmail.com

Today's Date: _____

Patient Registration Information

Please PRINT and complete ALL sections below.

Patient's Personal Information **Marital Status:** ☐Single ☐Married ☐Divorced ☐Widowed **Sex:** ☐Male ☐Female

Name: _____ _____ _____
Last Name First Name Initial

Social Security #: _____ - ____ - _____ Date of Birth: ___ / ___ / _____ Race: _____ Ethnic Group: _____

Address: _____ Apt. #: _____ City: _____ State: ____ Zip: _____

☐Home Phone:(____) _____ ☐Work Phone: (____) _____ ☐Cell Phone: (____) _____

Email Address: _____ Driver's License #: _____

How did you hear about us? _____

This is a confidential record: Please answer the following questions as completely as you can. If you are uncertain about the question, leave it blank. Information contained here will not be released without your authorization.

CURRENT PROBLEMS:

_____

_____

ALLERGIES: ☐No known allergies ☐Latex allergy ☐Iodine / Shellfish

DRUG / OTHER:	REACTION:
_____	_____
_____	_____
_____	_____
_____	_____

Medication Record: *Please list your preferred pharmacy that you currently use to fill your prescriptions.*

Name of Pharmacy: _____ City: _____ State: _____

Pharmacy's Phone #: _____

MEDICATIONS: (*Prescription, Over the Counter, Herbal Supplements, Etc.)*

☐ No Medications ☐ List copied and attached.

Medication / Strength:	Dose / Frequency:	Reason for Medication:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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PAST MEDICAL HISTORY:

- ☐ Arthritis ☐ Osteoarthritis ☐ Rheumatoid Arthritis
- ☐ Arrhythmia
- ☐ Bladder problems
- ☐ Blood clots in ☐ Legs ☐ Lungs? Require blood thinners? ☐ YES or ☐ NO
- ☐ Blood transfusion
- ☐ Bleeding disorder
- ☐ Cancer? What type or where: _____ Did you receive: ☐ Chemo ☐ Radiation
- ☐ High cholesterol or lipids
- ☐ Diabetes ☐ Diet controlled ☐ On oral medication ☐ On insulin
- ☐ High blood pressure
- ☐ Liver problems ☐ Cirrhosis ☐ Hepatitis, TYPE: _____
- ☐ Lung Problems ☐ COPD ☐ Tuberculosis ☐ Emphysema ☐ Asthma ☐ Sleep Apnea ☐ Shortness of Breath ☐ Lung Cancer ☐ Other
- ☐ Mental health problems ☐ Depression ☐ Bipolar ☐ Dementia ☐ Other
- ☐ Nerve or neuro problems ☐ Seizures ☐ Migraines
- ☐ Stroke / TIA Any residual deficits? _____
- ☐ Thyroid problems ☐ On medication
- ☐ Coronary artery disease ☐ Heart attack ☐ Congestive heart failure ☐ Arrythmia
- ☐ Peripheral vascular disease
- ☐ Skin disorder ☐ Psoriasis ☐ Skin cancer- ☐ Basal ☐ Squamous ☐ Melanoma
- ☐ Pancreas problems

PAST SURGICAL HISTORY:

Procedure:	Date if known:	
☐ Appendectomy	_____	
☐ Back surgery	_____	☐ Neck ☐ Thoracic ☐ Lumbar
☐ Colon surgery	_____	
☐ Bariatric surgery	_____	
☐ Colonoscopy / EGD	_____	☐ Polyps
☐ Gallbladder	_____	
☐ Heart	_____	☐ Pacemaker ☐ Bypass ☐ Stents
☐ Hernia	_____	
☐ Thyroid	_____	
☐ Tonsillectomy	_____	
☐ Abdominal surgery	_____	
☐ Knee surgery	_____	
☐ Hip surgery	_____	

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FAMILY HISTORY:

Do any of your blood relatives (parents, brothers/sisters, grandparents, aunts/uncles/cousins) have or ever had any of the following diseases? ☐ NONE ☐ Unknown Family History

	Relationship:	Age:	State of Health:	Age at Death:
☐ Cancer and what type	_____	_____	_____	_____
☐ Diabetes	_____	_____	_____	_____
☐ Heart disease / Problems	_____	_____	_____	_____
☐ High blood pressure	_____	_____	_____	_____
☐ Lung disease / Problems	_____	_____	_____	_____
☐ Stroke	_____	_____	_____	_____
☐ Kidney disease	_____	_____	_____	_____
☐ Blood disease	_____	_____	_____	_____
☐ Other	_____	_____	_____	_____

OCCUPATIONAL / SOCIAL HISTORY:

☐ Currently employed ☐ Retired ☐ Disabled

Employers Name: _____ Occupation: _____

Do you smoke? ☐ NO ☐ YES _____ Packs per day for _____ years

Previous smoker? ☐ NO ☐ YES _____ Packs per day for _____ years Quit Date: _____

Do you use smokeless tobacco products? ☐ NO ☐ YES What and how much? _____

Do you currently use any form of illegal substances? ☐ NO ☐ YES

Do you currently consume any alcohol? ☐ NO ☐ YES

If YES, how often? ☐ Daily ☐ Weekly ☐ Socially Type? ☐ Beer ☐ Wine ☐ Liquor

Do you exercise? ☐ NO ☐ YES How many times per week? _____

Do you eat healthy? ☐ NO ☐ YES

SPECIALIST PHYSICIANS: *Please list all other physicians you currently see.*

Physician:	Specialty:	Location:	Phone Number:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____