



NEW HORIZON MEDICAL HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:
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Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	<input type="checkbox"/> Sedentary (No exercise) <input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf) <input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.) <input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
	If yes please explain types of exercise:		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	# of meals you eat in an average day?		
	Rank salt intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
	Rank fat intake	<input type="checkbox"/> Hi <input type="checkbox"/> Med <input type="checkbox"/> Low	
Caffeine	<input type="checkbox"/> None <input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Cola		
	# of cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		
	How many drinks per week?		
	Are you concerned about the amount you drink?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you considered stopping?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever experienced blackouts?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you prone to "binge" drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you drive after drinking?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day <input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit	

Mental Health History

Is stress a major problem for you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel out of control when you eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you vomit, use laxatives or exercise to compensate for overeating?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you eat when you are stressed/angry or bored?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is anyone in your household overweight?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you work outside the home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
How many hours do you work in a typical day?		
Any stress at work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What is the greatest source of stress in your life right now?		
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you panic when stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past 3 months have you felt down, depressed or hopeless?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In the past 3 months have you had little or no interest/pleasure in doing things?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Men: In the past 3 months have you had more than 5 drinks in one day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
For Women: In the past 3 months have you had more than 4 drinks in one day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you cry frequently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever attempted suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever seriously thought about hurting yourself?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have trouble sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been to a counselor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, name of counselor:		
Phone number:		
Do you snore on most nights (more than 3 times a week)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your snoring loud? (heard through a door or a wall)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been told that you stop breathing or gasp during sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you occasionally doze, or fall asleep during the day when you are not busy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you doze or fall asleep while driving or stopped at a light?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Weight History

- What is the main reason you decided to lose weight?
- When did you begin gaining excess weight (give reasons if known)?
- What do you think is the main cause of your weight problems?

4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5. Is your spouse, fiancé, or partner overweight?
6. How often do you dine out? What restaurants do you frequent? What types of foods do you eat there?
7. List any food allergies:
8. What foods do you avoid?
9. What foods do you crave?
10. Do you awaken hungry during the night?
11. What are your worst food habits?
12. What are your snack habits?
13. Please provide your lowest adult weight with year.
14. Please list your highest adult weight with year.
15. Rate your body from 1 to 10. How would you describe your body?
16. If you could change one thing about your body, what would it be?
17. What do you feel will be your obstacle(s) to successful weight loss?
18. What is your typical breakfast? What time? Where? With whom?
19. What is your typical lunch? What time? Where? With whom?
20. What is your typical dinner? What time? Where? With whom?
21. Add additional comments you think would be helpful.
22. What is your personal goal weight today?
23. Are you willing to change ??

Thank You!

Accuracy Agreement

I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.

Signature:

Date:

PATIENT REGISTRATION FORM

NAME: _____

ADDRESS: _____

APT: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: () _____

DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY NUMBER _____

EMPLOYER: _____

BUSINESS ADDRESS: _____

SPOUSE: _____ SPOUSE EMPLOYER: _____

REFERRED BY: _____ PRIMARY CARE MD _____

*PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE):

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: () _____

NEAREST RELATIVE TO NOTIFY IN CASE OF AN EMERGENCY:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ PHONE: () _____

INSURANCE:

1. _____ INSURED ID: _____ GROUP # _____

2. _____ INSURED ID: _____ GROUP # _____

AUTHORIZATIONS:

I HEREBY AUTHORIZE PAYMENTS BY MY INSURANCE CARRIER BE MADE DIRECTLY TO THE PROVIDER OF THESE SERVICES.

YES _____ NO _____

I UNDERSTAND I AM RESPONSIBLE FOR ANY PORTION OF THE BILL NOT COVERED BY MY INSURANCE CARRIER. I UNDERSTAND I AM RESPONSIBLE FOR GETTING ANY REQUIRED REFERRALS OR AUTHORIZATIONS FROM MY PRIMARY CARE PHYSICIAN, AS STIPULATED BY MY INSURANCE CARRIER, FOR MY TREATMENT AT THIS OFFICE.

YES _____ NO _____

I HEREBY AUTHORIZE RELEASE OF INFORMATION FOR INSURANCE CLAIM PURPOSES.

YES _____ NO _____

I UNDERSTAND ALL OF THE ABOVE AND HEREBY STATE THE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: _____ SIGNED: _____