NEW HORIZON MEDICAL
HEALTH HISTORY QUESTIONNAIRE

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

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

HEALTH HABITS AND PERSONAL SAFETY

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

Mental Health History

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

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

Name the Drug	Strength	Frequency Taken

Weight History

1. What is the main reason you decided to lose weight?
2. When did you begin gaining excess weight (give reasons if known)?
3. 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 on 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 EMERCENCY:

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 RELASE 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:____