PLEASE PRINT ALL INFORMATION CLEARLY Today's Date _____

Full Name _____ Date of Birth _____

Street Address _____ City/State/Zip _____

Home Phone _____ Cell _____ Work Phone _____

Occupation/ Place of Employment _____ SS# _____

Spouse's Name _____ Primary Care M.D._____

Email _____ Age_____ Height _____ Sex _____

Do you now have or have you ever been treated for any of the following:

	No	Yes	PLEASE LIST **ALL** CURRENT MEDS
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Thyroid Disorder	_____	_____	_____
Hormones or Birth Control	_____	_____	_____
High Cholesterol	_____	_____	_____
Depression	_____	_____	_____
Sleep Disorder	_____	_____	_____
Lung Disease e.g. Asthma	_____	_____	_____
Glaucoma			_____
Any other regular medicines	_____	_____	_____
	_____	_____	_____

__ Please list any major surgeries you have had _____

__ Please list any other serious illnesses you have had _____

__ Have you ever had or been treated for alcohol or other substance abuse/dependence? _____

__ What would you like to weigh (goal weight?) _____ At what age were you last at that weight? _____

__ Any previous prescription weight loss medications? _____

__ Do you smoke? _____

__ Menses regular? _____ # Children _____ Are you pregnant? _____

__ Any family history of: Heart Disease _____ Obesity _____ Cancer _____
High Cholesterol _____ Stroke _____

__ Do you exercise regularly? _____ How often? _____ Any problems with exercise? _____

__ Do you eat nutritiously? _____ excessively? _____ Do you count calories? _____

__ Have you been overweight all your life? _____ If not, how long? _____

__ Any allergies to medicines? Please list _____

Rochester Medical Weight Loss

Thank you for coming in to see us! Please tell us how you found us:

Please circle any that apply:

1. I was a previous patient
2. My doctor referred me
3. I found you in a newspaper/magazine: which one?
4. I found your webpage on the internet

5. A friend or family referral: Whom?
6. Other (please specify)

Past Medical History: (check all that apply)

____Polio	____Sleep Apnea	____Diabetes	____Jaundice
____Measles	____Mumps	____Tonsillitis	____Kidney Disease
____Scarlet Fever	____Liver Disease	____Lung Disease	____Whooping Cough
____Rheumatic Fever	____Chicken Pox	____Bleeding Disorder	____Nervous Breakdown
____Ulcers	____Thyroid Disease	____Psychiatric Illness	____Tuberculosis
____Heart Valve Disorder	____Alcohol Abuse	____Eating Disorder	____Drug Abuse
____Blood Transfusion	____Pneumonia	____Malaria	____Typhoid Fever
____High Blood Pressure	____Cholera	____Cancer	____Osteoporosis
____Arthritis	____Gout	____Metabolic Syndrome	____Polycystic Ovarian Syndrome

____Elevated Cholesterol

____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? (Give reasons, if known):
   _____
   _____
   _____
5. When did you begin gaining excess weight? (give reasons, if known):
   _____
   _____
   _____

6. What has been your maximum lifetime weight (non-pregnant) and when?

_____

_____

_____

Nutrition Evaluation (Continued):

7. Pervious Diets you have followed: Give dates and results of your weight loss

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8. Is your spouse, fiancée or partner overweight? Yes Or No (circle one)

9. By how much is he or she overweight? _____

10. How often do you eat meals prepared outside of your home? _____

11. What restaurants do you visit frequently?

_____

_____

12. How often do you eat “fast foods”? _____

13. Who plans meals? _____ Cooks? _____ Shops? _____

14. Do you use a shopping list? Yes Or No (circle one)

15. What time of day and on what day do you usually shop for groceries? _____

MISSED APPOINTMENT POLICY

In an effort to better serve our patients, we ask that you give a minimum of 24 hour notice if you are unable to keep your appointment. We will be happy to reschedule your appointment for a time that is more convenient for you. This time has been reserved for you, and your health care is important to us.

If you do not cancel your appointment with at least a 24 hour advance notice or you fail to keep your appointment, you may receive a charge of $50.00.

An excessive amount of missed appointments could result in being discharged from our practice.

LATE POLICY

If you are late for your appointment, the receptionist will do the following:

- Check with the provider or staff and see if you can be seen without delaying other scheduled appointments
- Reschedule for another day
- Reschedule same day for a different time

CELLPHONES AND PAGERS

To ensure that you have uninterrupted, quality time with your health care provider during your examination, we ask that you turn off your cell phone or your pager when you enter the examination room.

Thank you,

Print Name _____

Signature _____ Date _____

Your Rights and Confidentiality

You have the right to leave treatment at any time with any penalty, although you do have the make sure you are discontinuing treatment. Your personal physician must be able to assume your medical care.

From time to time, patient treatment information is used in the collection of statistics to compare results, and improve the treatment of obesity. This information may be shared with other practitioners, researchers, and the scientific and medical community. Strict confidentiality of individual personal information and records will be maintained.

(HIPPA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU GET ACCESS TO THIS INFORMATION

Uses and Disclosures of Information that We May Make Without Written Authorization:
Treatment, payment, healthcare operations, required by law, abuse or neglect, or communicable diseases, public health activities, health oversight activities, judicial and administrative proceedings, law enforcement, organ donation , research, workers compensation, appointments and services, marketing, business associates, military, inmates or person in police custody.

Uses and Disclosures of Information that We May Make Unless You Object: We may use and disclose protected health information in the following instances without your written authorization unless you object. If you object, please notify the Privacy Contact identified at the end of this document.

Persons involved in your health care: Unless you object, we may disclose protected health information to a member of your family, relative, close friend, or other person identified by you who is involved in your health care or the payment for your health care. We will limit disclosure to the protected health information relevant to that person's involvement in your health care of payment. We may leave message for you to call us or leave basic lab test results on your phone unless you direct otherwise.

Notification: Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition.

Your Right Concerning your Protected Health Information: You have the following rights concerning your protected health information. To exercise any of these rights, you must submit a written request to our privacy officer.

1. To request additional restrictions.
2. To receive communications by alternative means.
3. To inspect and copy records.
4. To request amendment to your record.
5. To request accounting of certain disclosures.
6. To receive a copy of our complete confidentiality notice.
7. To receive a copy of the bill to submit to your insurance. We will code your visit as medically correct as possible.

Please note in rare instances a new diagnosis or prescription that you submit to your insurance may affect your insurability and/or your insurance rates.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

Entities to Whom This Notice Applies: The notice applies to Rochester Medical Weight Loss, PC, their associated clinics, the physicians, employees, and volunteers that work there.

I, the undersigned, have reviewed this information on the front and back of this document, and have had an opportunity to ask questions and have them answered to my satisfaction.

X _____

Date _____