



Name: \_\_\_\_\_

## NUTRITION HISTORY

How many meals do you eat daily? \_\_\_\_\_

Do you snack between meals  Yes  No

Do you drink soda  Yes  No      Regular Soda?  Yes  No      Diet Soda?  Yes  No

How many sodas do you drink daily? \_\_\_\_\_

### FOOD PREFERENCES

Candy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fast food	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cookies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seafood	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fried food	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cakes or pies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pizza	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vegetables	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chocolate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Steak or red meat	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chips & snacks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dairy products	<input type="checkbox"/> Yes <input type="checkbox"/> No

### FOOD ALLERGIES

*Please list any food allergy you have*


### FOOD PATTERNS

*Please record the type of food and the amount you have eaten over the past two days.*

	All foods eaten yesterday	All foods eaten the day before yesterday
Before breakfast		
Breakfast		
Morning break		
Lunch		
Afternoon snack		
Dinner		
After dinner		
Before bed		
Other		

Name: \_\_\_\_\_

## WEIGHT LOSS HISTORY

How tall are you? _____	How much do you currently weight? _____
What was your best weight loss with dieting?	
What is your goal weight?	

### PRIOR WEIGHTS

List maximum weight for each year:			
2008		2007	
2006		2004	
2003		2002	

*Many insurance companies require documentation of weight for 3-5 years. Please have your primary care physician fax records that document your weight over that time.*

### NON-SUPERVISED WEIGHT LOSS ATTEMPTS

Body For Life/Bill Phillips <input type="checkbox"/>	Low carbohydrate <input type="checkbox"/>	Atkins Diet <input type="checkbox"/>	Scarsdale Diet <input type="checkbox"/>
Gloria Marshall <input type="checkbox"/>	Low fat <input type="checkbox"/>	AYDS <input type="checkbox"/>	Stillman Diet <input type="checkbox"/>
Health spa <input type="checkbox"/>	Calorie counting <input type="checkbox"/>	Mayo Clinic Diet <input type="checkbox"/>	Sugar Busters <input type="checkbox"/>
High protein <input type="checkbox"/>	Gym membership <input type="checkbox"/>	Pritikin <input type="checkbox"/>	Slim Fast <input type="checkbox"/>
Hypnosis <input type="checkbox"/>	Home gym equipment <input type="checkbox"/>	Richard Simmons <input type="checkbox"/>	South Beach Diet <input type="checkbox"/>
Other (List): _____			

### SUPERVISED WEIGHT LOSS ATTEMPTS

Diet Pills From MD <input type="checkbox"/>	Health Management <input type="checkbox"/>	National Weight Loss <input type="checkbox"/>	Weight Loss Center <input type="checkbox"/>
Diet Shots From MD <input type="checkbox"/>	Resources <input type="checkbox"/>	Supervised Calorie <input type="checkbox"/>	Exercise Counseling <input type="checkbox"/>
Diet Center <input type="checkbox"/>	Nutri-System <input type="checkbox"/>	Counting <input type="checkbox"/>	Medifast <input type="checkbox"/>
Overeaters Anonymous <input type="checkbox"/>	T.O.P.S. <input type="checkbox"/>	Acupuncture <input type="checkbox"/>	Metrical <input type="checkbox"/>
Optifast <input type="checkbox"/>	Jenny Craig <input type="checkbox"/>	Psychological Counseling <input type="checkbox"/>	Nutritional counseling <input type="checkbox"/>
Weight Watchers <input type="checkbox"/>	New Direction <input type="checkbox"/>	Weigh Of Life <input type="checkbox"/>	Personal Trainer <input type="checkbox"/>
Other (List): _____			

### WEIGHT LOSS MEDICATIONS

Acutrim <input type="checkbox"/>	Didrex <input type="checkbox"/>	Metabolife <input type="checkbox"/>	Pondimin <input type="checkbox"/>
Adipex-P <input type="checkbox"/>	Fastin <input type="checkbox"/>	Obalan <input type="checkbox"/>	Redux <input type="checkbox"/>
Alli <input type="checkbox"/>	Fenfluramine <input type="checkbox"/>	Orlistat <input type="checkbox"/>	Sanorex <input type="checkbox"/>
Amphetamines <input type="checkbox"/>	Herbal Remedies <input type="checkbox"/>	Phendiet <input type="checkbox"/>	Tepanol <input type="checkbox"/>
Anorex <input type="checkbox"/>	Ionamin <input type="checkbox"/>	Phentermine <input type="checkbox"/>	Tenuate <input type="checkbox"/>
Benzphetamine <input type="checkbox"/>	Mazanor <input type="checkbox"/>	Phentro <input type="checkbox"/>	Wehless <input type="checkbox"/>
Dexatrim <input type="checkbox"/>	Meridia <input type="checkbox"/>	Plegine <input type="checkbox"/>	Xenical <input type="checkbox"/>

Name: \_\_\_\_\_

## MEDICAL HISTORY

*Please check and explain any of the items below*

### CARDIOVASCULAR

High Blood Pressure	<input type="checkbox"/>	
Previous heart attack	<input type="checkbox"/>	
Chest pain or tightness	<input type="checkbox"/>	
Heart failure	<input type="checkbox"/>	
Rheumatic fever	<input type="checkbox"/>	
Heart valve problems	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	High Triglycerides <input type="checkbox"/>

### DIABETES AND ENDOCRINE SYSTEM

Diabetes Mellitus	<input type="checkbox"/> None	<input type="checkbox"/> Type I	<input type="checkbox"/> Type II	
When was your diabetes first diagnosed?				
How long have you been taking	Oral agents?	Insulin?		
Does your diabetes resolve with weight loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
How often do you test your blood sugar at home?				
What are your usual blood sugars? Give a range:				
Pre-diabetic (Abnormal glucose tolerance test)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had Gestational Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Type: _____	

### GASTROINTESTINAL

<b>GALLBLADDER</b>				
Do you have gallstones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had your gallbladder removed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>STOMACH</b>				
Stomach Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gastritis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you previously taken medicine for ulcers or gastritis? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Heartburn	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often?	<input type="checkbox"/> Daily <input type="checkbox"/> Occasionally <input type="checkbox"/> Rarely
Do you take medications for heartburn?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Which one?	
Have you had an upper endoscopy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When?	
<b>COLON</b>				
Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Crohn's disease or Ulcerative Colitis
				<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a colonoscopy?			<input type="checkbox"/> Yes <input type="checkbox"/> No	When?
<b>LIVER</b>				
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____	Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name: \_\_\_\_\_

## MEDICAL HISTORY

*Please check and explain any of the items below*

### RESPIRATORY

Asthma	<input type="checkbox"/>	Last attack?
Emphysema or COPD	<input type="checkbox"/>	
Bronchitis	<input type="checkbox"/>	Number of times in past 2 years?
Pneumonia	<input type="checkbox"/>	
Problems with anesthesia	<input type="checkbox"/>	What type?
Blood clots in legs	<input type="checkbox"/>	Blood clots in legs <input type="checkbox"/>
Family history of blood clots	<input type="checkbox"/>	Who in the family?

### SLEEP APNEA

Have you been diagnosed with Sleep Apnea?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you previously had a sleep study	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use CPAP or BIPAP	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered No to the above, answer the following questions:

Do you snore?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you been told that you hold your breath or stop breathing during sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wake up gasping for breath?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you awaken with headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you fall asleep frequently while reading?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you fallen asleep while driving or stopped at a light?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have jerking movements while sleeping?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you often wake up with a dry mouth or sore throat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you still feel exhausted after 8 hours of sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### MUSCULOSKELETAL

	Mild	Moderate	Severe
Hip Pain			
Knee Pain			
Ankle Pain			
Foot Pain			
Back Pain			
Neck Pain			

Are you using anti-inflammatory medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you using narcotic pain medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Name: \_\_\_\_\_

## MEDICAL HISTORY

*Please check and explain any of the items below*

### KIDNEY AND BLADDER

Do you spill urine when coughing or sneezing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you had bladder infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Have you had kidney infections <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had kidney stones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

### NEURO-PSYCHIATRIC

Depression <input type="checkbox"/> Yes <input type="checkbox"/> No		Is your depression due to obesity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been in counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No		Severe Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual problems <input type="checkbox"/> Yes <input type="checkbox"/> No		Type: _____	
Eating Disorders:	<input type="checkbox"/> None	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Anorexia Nervosa <input type="checkbox"/> Other: _____

### OTHER

Do you bleed or bruise easily? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you ever had a blood transfusion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have swelling of your legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have varicose veins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have ulcers of the legs? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have HIV or AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### FOR WOMEN

Have you had problems conceiving?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
How many pregnancies have you had?			How many children do you have?
Any pain with your period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you have Polycystic Ovarian Syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are you on Birth Control?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Method: _____

## PRIOR SURGERIES

*Please list all the surgeries you had done and when you had them:*

Surgery	Year





Name: \_\_\_\_\_

## OFFICE POLICY AND FINANCIAL RESPONSIBILITY

Please read the following office policies. We would like for you to read and sign accordingly. Thank you for choosing Surgical Associates at Virginia Hospital Center.

*It is your responsibility to be aware of your insurance policy. Please provide us with a current insurance card at the time of check-in. You will be asked at all subsequent visits if your insurance and/or demographic information has changed. If you fail to give our office your new insurance card, you may be responsible for the full office charge. You are required to pay any applicable co-pays or current balances at the time of check-in unless you have made prior arrangements with the Practice Administrator.*

*Surgical Associates at Virginia Hospital Center is not responsible if you fail to obtain the required authorization. If a referral is required for your insurance, you - the patient - are responsible to obtain the referral prior to your visit from your Primary Care Physician. If you do not have the required referral at the time of your appointment, payment will be due at the time of service. If there are any issues regarding your appointment, we can reschedule your appointment at your convenience.*

If you are not able to keep your appointment, please provide 1 (one) business day notice. Failure to provide appropriate notice will result in a \$35 fee for the missed appointment. We understand that emergencies happen and will take into consideration before any chargers are applied to your account.

Surgical Associates at Virginia Hospital Center will make every attempt to ensure you are seen in a timely manner. However our surgeons are occasionally called to emergencies. This may delay your appointment or you may be asked to reschedule your appointment. We appreciate your patience and understanding.

I have read the above policy.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

Name: \_\_\_\_\_

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use and disclosure of my Protected Health Information (PHI) by Surgical Associates at Virginia Hospital Center for the purposes of diagnosing or providing treatment for me, obtaining payment for my health care bills or to conduct health care operations for the practice of Surgical Associates at Virginia Hospital Center. I understand that diagnosis or treatment of me by Surgical Associates at Virginia Hospital Center may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have a right to request a restriction as how my "PHI" is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Surgical Associates at Virginia Hospital Center is not required to agree to the restrictions that I may request. However, if Surgical Associates at Virginia Hospital Center agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Surgical Associates at Virginia Hospital Center has taken action in reliance on this consent.

My "PHI" means health protection, including my demographic information, collected from me and created or received by my physician, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This "PHI" related to my past, present or future physical or mental health condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Virginia Hospital Center Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my "PHI" that will occur in my treatment, payment of my bills or in the performance of healthcare operations of the practice. The Notice of Privacy Practices for the practice is also provided to the front desk. This Notice of Privacy Practices also describes my rights and the practice's duties with respect to my "PHI".

Surgical Associates at Virginia Hospital Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting one in the mail or by asking for one at the time of my next appointment.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date