Weight Loss Management

Patient Name: ________________________________ Date of Birth/Age: _________ Date: ________

Are you an existing patient of Copper Valley Medical, LLC? __**Y** __**N** If so, please skip to page 8.
If not, would you like to establish care here? __**Y** __**N**
If you have a primary care provider: ____
Name | Contact Information

Current Medications:
Medication: ______________________________ Dose: ______________ Frequency: __________
Medication: ______________________________ Dose: ______________ Frequency: __________
Medication: ______________________________ Dose: ______________ Frequency: __________
Medication: ______________________________ Dose: ______________ Frequency: __________
Medication: ______________________________ Dose: ______________ Frequency: __________

Current Supplements:
Supplement: ______________________________ Dose: ______________ Frequency: __________
Supplement: ______________________________ Dose: ______________ Frequency: __________
Supplement: ______________________________ Dose: ______________ Frequency: __________

Do you have drug or food allergies? __Y __N __ Sulfa Drugs __ Latex Powder __ Penicillin __ Other: ________

Have you ever been told to avoid certain foods or drugs? __Y __N ____________________________________

Are you now, or do you intend to become pregnant in the next 12 months? __Y __N

Smoking History:

Do you currently smoke? N __ Yes: Cigarettes __ (Packs per day) Cigars __ (Cigars/day) Pipe __ (Times/day) Other: _____________

Do you want to quit smoking? __Y __N

__Past or current smoker Date last smoked: ____________________ Packs/Day Smoked: ________________

Diet:

Typical Breakfast: ____ Time: __________

Typical Lunch: ____ Time: __________

Typical Dinner: ____ Time: __________

Snacks: ____

Water Intake: ____________ oz/day Coffee intake ____________________ Soda intake: ________________

Bowel Movements:

How many bowel movements do you typically have each day: 0—1—2—more
How would you describe your recent stools? __Solid; no strain to pass __Hard; difficult to pass __Loose
__Foul-smelling __Floating __Greenish __White/Clay-colored

Do you use laxatives? **Y N**
How frequently? __Daily 3+/Week 3+/Month __ Rarely or Never

Patient Name: ________________________________

Have you recently noticed blood on the tissue or in the water after your stool: **Y N**
Have you noticed or suspected hemorrhoids: **Y N**
If yes, what level of pain: 1--------5--------10 (10 is worst)

Energy Level:
What has your energy level been for the past several days? 1--------5--------10 (10 is best)
How much sleep is normal for you? 4—6—8 –10 hours per night

Stress: How would you rate your current stress level: 1--------5--------10 (10 is worst)
What is the primary cause of your stress? ____

Occupation: What type of work do you do?
__Full-time Student __Part-time student __Retired; How long? ____________________
__Teacher/Instructor __Hospitality __Entertainment
__Service Industry __Landscape/Pest Control __Auto Repair
__Outside Sales __Retail Sales __Research
__Office Type of business: ____
__Healthcare Type of clinic or facility: ____

Other: ____

Social History:
__Past or current ETOH Use Date of last use: ____________________ ETOH Volume/Day: ________________

__ETOH Dependency Are you a recovering alcoholic? **Y N** (Some medications are alcohol-based)
__Past or current recreational drug use Drugs used: ____
__Prescription Drug Dependency Drug(s): ____

Do you exercise on a regular basis? Y N If yes, please describe the type and frequency of your exercise**:**
____
____
____

Current Marital Status:
__Single __ In a significant, long-term relationship, but not married __ Married
__Divorced __ Widowed (_____ Years) __Never Married

Hospitalizations: Age/Reason ____
Age/Reason ____
Age/Reason ____

Surgeries: Age/Reason ____
Age/Reason ____
Age/Reason ____
Age/Reason ____

Patient Name: ___________________________________

Have you have the following Disease(s) **(D),** Been Vaccinated **(V),** or Neither **(N):**

Measles	**D**	**V**	**N**	**Hemophilia**	**D**	**V**	**N**	**Rubella**	**D**	**V**	**N**
Mumps	**D**	**V**	**N**	**Chicken Pox**	**D**	**V**	**N**	**Tetanus**	**D**	**V**	**N**
Hep B	**D**	**V**	**N**	**Whooping Cough**	**D**	**V**	**N**	**Rubeola**	**D**	**V**	**N**
HIB	**D**	**V**	**N**	**Shingles**	**D**	**V**	**N**	**Meningitis**	**D**	**V**	**N**

Any vaccination reactions? ____

Have you been diagnosed with any of the following chronic diseases? Please circle all that apply.

Asthma
Chest Pain
Diabetes mellitus Type I
Diabetes mellitus Type II
Heart Disease
Irritable Bowel Disease
Kidney Disease
Seizure Disorders
Valley Fever/Cocci
Tuberculosis
Thyroid Disease
Ulcer (Peptic/Gastric)
Valley Fever/Cocci
Cancer
Rheumatoid Arthritis
Sjogren's Disease
SLE (Lupus)

Please answer the following questions by circling Y for yes, N for no, or P for past

SKIN

Rash:	**Y N P**	Color Change:	**Y N P**
Hives:	**Y N P**	Lump:	**Y N P**
Psoriasis/eczema:	**Y N P**	Itchy:	**Y N P**
Dry:	**Y N P**	Warts/moles:	**Y N P**
Cancer:	**Y N P**	Perspiration:	**Y N P**

HEAD

Headache:	**Y N P**	Migraine:	**Y N P**
Dandruff:	**Y N P**	Head Injury:	**Y N P**
Oil/Dry Hair:	**Y N P**	Hair Loss:	**Y N P**

NOSE

Frequent Colds:	**Y N P**	Nosebleeds:	**Y N P**
Congestion:	**Y N P**	Post Nasal Drip:	**Y N P**
Polyps:	**Y N P**	Seasonal Allergies:	**Y N P**

EYES

Dry/Watery:	**Y N P**	Blurry Vision:	**Y N P**
Double Vision:	**Y N P**	Cataracts:	**Y N P**
Glaucoma:	**Y N P**	Styes:	**Y N P**
Strain:	**Y N P**	Discharge:	**Y N P**
Itchy:	**Y N P**	Dark Under Eyelid:	**Y N P**

Patient Name: ___________________________________

MOUTH/THROAT

Canker Sores:	**Y N P**	Cold Sores:	**Y N P**
Sore Throat:	**Y N P**	Gum Disease:	**Y N P**
Dentures:	**Y N P**	Cavities:	**Y N P**
Loss of Taste:	**Y N P**	Hoarseness:	**Y N P**

NECK

Stiffness:	**Y N P**	Swollen Glands:	**Y N P**
Full Movement:	**Y N P**	Tension:	**Y N P**

RESPIRATORY

Cough:	**Y N P**	TB:	**Y N P**
Shortness of breath w/exertion:	**Y N P**	Bronchitis:	**Y N P**
Shortness of breath sitting:	**Y N P**	Pneumonia:	**Y N P**
Shortness of breath lying:	**Y N P**	Asthma:	**Y N P**
Wheezing:	**Y N P**	Painful breathing:	**Y N P**

CARDIOVASCULAR

High Blood Pressure:	**Y N P**	Rheumatic Fever:	**Y N P**
Low Blood Pressure:	**Y N P**	Murmurs:	**Y N P**
Arrhythmias:	**Y N P**	Palpitations:	**Y N P**
Edema:	**Y N P**	Chest Pain:	**Y N P**

URINARY TRACT

Incontinence:	**Y N P**	Pain w/Urination:	**Y N P**
Frequent Infections:	**Y N P**	Kidney Stones:	**Y N P**
Urgency:	**Y N P**	Discharge/Blood:	**Y N P**

GASTROINTESTINAL

Heartburn:	**Y N P**	Bowel Movement Freq:	
Indigestion:	**Y N P**	Recent BM Change:	**Y N P**
Bloating:	**Y N P**	Diarrhea/Constipation:	**Y N P**
Nausea:	**Y N P**	Hemorrhoids:	**Y N P**
Vomiting:	**Y N P**	Gall Bladder Disease:	**Y N P**
Change In Appetite:	**Y N P**	Liver Disease:	**Y N P**
Pancreatitis:	**Y N P**	Ulcer:	**Y N P**

MUSCULOSKELETAL

Weakness:	**Y N P**	Arthritis:	**Y N P**
Stiffness:	**Y N P**	Leg Cramps:	**Y N P**
Tremors:	**Y N P**	Pain:	**Y N P**

Patient Name: ___________________________________

NERVOUS

Paralysis:	**Y N P**	Sciatica:	**Y N P**
Tingling/numbness:	**Y N P**	Carpal tunnel syndrome:	**Y N P**
Seizures:	**Y N P**	Fainting:	**Y N P**

MENTAL/EMOTIONAL

Depression:	**Y N P**	Anger/irritability:	**Y N P**
Suicidal:	**Y N P**	High-strung/tense:	**Y N P**
Anxiety:	**Y N P**	Fear/Panic:	**Y N P**
Eating disorder:	**Y N P**	Psych Hospitalization:	**Y N P**

TOXIN EXPOSURE

Have you ever lived in an area you considered to be polluted, such as near a refinery? **Y N**

Have you ever lived in a house with lead-based paint? **Y N**

Have you ever used Mexican pottery, or other cookware now known to be painted with lead-based paints? **Y N**

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? **Y N**

Have you ever been sensitive to perfumes, gasoline or other vapors? **Y N**

Do you use pesticides, herbicides or other chemicals around your home? **Y N**

____
____
____
____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	________	________	________	________	________	________
Age when died:	________	________	________	________	________	________
Reason for death:	________	________	________	________	________	________
Cancer type:	________	________	________	________	________	________
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/ Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

____

Patient Name: ___________________________________

Have you recently had any laboratory studies (blood, urine) or imaging (x-rays, CT, MRI, Ultrasound) Y N

Recent Labs: CMP CBC/Diff TSH Other: ______________________________

Recent Imaging: X-rays CT Scan MRI Details:______________________________

Last Eye exam: ______________________________ Last Dental exam: ______________________________

Last DEXA/NTX: ____

Colonoscopy: _________________________________ Last DRE/PSA: ____________________________________

Men Only	
▪ Do you experience pain or discomfort in or around your groin or testes with lifting or straining?	Y N
▪ If yes, have you ever been evaluated for or diagnosed with a hernia?	Y N
▪ Do you experience pain with urination?	Y N
▪ Have you recently noticed a discharge from your penis?	Y N
▪ Have you recently noticed a wart, growth, or sore in your genital region?	Y N
▪ If yes, have you ever been evaluated for or diagnosed with a sexually transmitted infection?	Y N
▪ Do you have any difficulty beginning or maintain a stream of urine?	Y N
▪ Do you frequently need to get up during sleep to urinate?	Y N
▪ Have you recently noticed blood in your urine?	Y N
▪ Are you satisfied with the currently flow of urine?	Y N
▪ Have you ever been evaluated for, or diagnosed with: ___BPH ___Prostate Cancer	Y N
▪ When did you most recently have a rectal examination:	
▪ Do you have difficulties achieving or maintaining an erection?	Y N
▪ Do you have difficulties achieving climax?	Y N
▪ Have you ever noticed blood in your stool?	Y N
▪ Have you ever had a colonoscopy? Date:	Y N
Do you have any concerns about your health?	Y N

Patient Name: ____________________________________

Women Only

All Women:

- Your age when you began to have a monthly cycle (menarche): ____________ years
  Children:
  Number: Ages: Health Status:___________________________________
  PGYs: Rh Status: _____________________________________
  Have you ever miscarried or aborted a pregnancy? **Y N**
- Date of your last PAP exam: _______________________ Result: _____________________________
- Have you noticed warts, sores or red areas in your genital area? **Y N**
- Have you had a hysterectomy? **Y N**
  - If yes:
    - Your age at the time of the hysterectomy: _______________
    - Was your uterus removed? **Y N**
    - Were your ovaries removed? **Y N**
      Are you currently using any hormones? __Estrogen __Progesterone __Other
- Have you ever been diagnosed with cancer of the: __Vulva __Cervix __Uterus __Ovaries

- Current and Recent Sexual Habits: __Active __Not Active
  __Monogamous Is your partner Monogamous **Y N**
  __Multiple Partners (Partners in the past 90 days: _______) Safe Practices:__ ____________
  __Heterosexual __ Homosexual __Bisexual

Breast Health

- Have you ever been diagnosed with breast cancer **Y N**
  - If yes, did you undergo any of the following treatments:
    __Radical mastectomy __Lumpectomy __Removal of Lymph Nodes
    __Chemotherapy __Radiation therapy __Other: ________________________

Date of last mammogram: ____________________ Date of last clinical breast exam: _____________
Do you perform monthly breast self-exams? **Y N**
Have you noticed any lumps, bumps, dimpling? **Y N**
Do you experience breast pain during menstrual periods? **Y N**
Have you noticed unusual nipple discharges? **Y N**

Non-menopausal: Last menstrual period (start of bleeding): ______________________
How heavy is your period? Days ____ Pads____ Tampons
Do you observe blood clots? **Y N**
Do you experience PMS? **Y N**

- Are you trying to become pregnant? **Y N**
- Are you currently using any form of birth control? _________________________________ _ **Y N**

In Menopause: When was your last period? Date:
Are you currently experiencing symptoms of menopause: **Y N**

Post-menopausal: At what age did you enter menopause: _____ years of age
Have you experienced any of the following:
__vaginal dryness or itching __pain with intercourse
Are you currently using any hormones? __Estrogen __Progesterone __Other

Patient Name: ___________________________________

Weight Loss Patients Only

- At what age did you first become overweight? (age)_______ (year) _______
- How or why did your weight gain start? ____
  ____
- What do you think is the reason for your weight problem? ____
- What is your present weight? ____ lbs. What is your weight goal? ___ lbs.
- What has been your highest weight (excluding pregnancy)? ________ lbs. Age at that time: _____
- What was your lowest, normal adult weight? ___ lbs. Age at that time: _____
- Have you previously attempted to lose weight? **Y N**
  - If yes, how much did you lose? __ lbs
  - How long did this take? _____________
- What method(s) of weight loss have you tried?
  - Diet: Adkins Mediterranean South Beach
  - Diet Programs: Weight Watchers NutriSystem Jenny Craig Summit
  - Pills Phentermine Fen-Phen
  - Injections MIC B_{12} HCG
  - Hypnosis
  - Acupuncture
  - Which method(s) worked best for you? ____
    - How much did you lose? ______ lbs How long did you keep it off? ____ weeks/months/years

Do you think you overeat or eat poor quality foods? __**Y** __**N**

Are you able/willing to make a lifestyle change to lose weight and keep it off? __**Y** __**N**

Are you able to modify your diet to lose weight? __**Y** __**N**

Are you able to self-inject with a small, painless needle? __**Y** __**N**

Important Information about the HCG Diet

HCG, the human chorionic gonadotropin hormone, naturally plays a significant role in managing a woman's menstrual cycle. It is known to reach very high levels during pregnancy, and is commonly used as a fertility drug and to control irregular cycles. If you are a woman of child-bearing potential, please be advised of the risk of pregnancy associated with the use of HCG.

____ _____________

Signature of Patient Date