Medical Weight Loss Center of Lancaster

Dr. David J Silverstein Associates

2920 Marietta Avenue, Lancaster, PA 17601

WEIGHT LOSS PATIENT HISTORY

Name_____ Social Security#____--____--_____
Address: _____ City/State: _____ Zip:_____
☐ Home Phone: ( )_____-_____ ☐ Cell: ( ) _____-_____
Email: _____

Please indicate above which phone number you wish for us to leave messages with medical information.
Date of Birth _____/_____/_____ Age: _____ Marital Status: S M W D
Occupation: _____

Primary Insurance:_____
Secondary Insurance: _____

Is the patient the subscriber or policy holder to the Primary Insurance?: Yes / No
Is the patient the subscriber or policy holder to the Secondary Insurance?: Yes / No
Subscriber / Policy Holder Name:

INSURED PATIENTS (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card.

Relationship to Patient: _____
Address: _____
Social Security Number: _____
Date of Birth: _____
Work Phone Number: _____

Emergency Contact:_____ Relationship to Patient: _____
Address: _____ Phone Number: _____

Primary Physician: _____ Primary physician phone #: _____
Preferred Pharmacy:_____ Pharmacy phone: _____

• Your lifetime (non-pregnant) max weight: _____ pounds (lbs)• Your goal weight: _____

•Age when you were last at your goal weight: _____ • What was your weight 1 year ago? _____

• What was your weight 5 years ago? _____ •20 years ago? _____

• Do you smoke? Y N •Drink Alcohol? Y N •How much? _____/day or week

• LADIES: Are your periods regular? Y N If not, do you skip periods? Y N • Last period? _____

• ? Infertility _____ •? Unwanted hair? Y N • Are you Pregnant? Y N •Breastfeeding? Y N

• Do you plan on becoming pregnant in the next few months?

• Birth control method (includes male or female sterilization): _____

• MEN: Muscles Weak? Y N •Low Sex Drive ? Y N • Erectile Dysfunction Y N •Low Energy? Y N

What have you done in the past to try to lose weight? Circle all that apply:

Weight Watchers	Purging/Vomiting	Medifast	Jenny Craig	Atkin's Diet
Diet pills	Starvation	Nutrition Consult	HCG	Low Carb
Surgery	NutriSystem	Optifast	Overeaters Annonymous	Other

Current Meds and doses:	**Reason for taking it?**	**Over the counter meds/herbals**
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____
5.) _____	_____	_____
6.) _____	_____	_____
7.) _____	_____	_____
8.) _____	_____	_____
9.) _____	_____	_____

Please list Any Major Surgery (including weight loss surgery)

Specify: (List all) Date

• Any known drug allergies? _____

Please **circle** the medical conditions that **YOU** have been diagnosed with in the past or currently:

High Blood Pressure	High Cholesterol	Heart Disease/Heart Failure	History of Heart Attack	Syncope (passing out)	Pacemaker or Defibrillator
History of Heart Valve problems or Arrhythmia	Heartburn/GERD	Thyroid Disease	Liver Disease	Kidney Disease	Asthma
Diabetes (insulin dependent or other injection)	Diabetes (oral medications)	Pre-Diabetes or metabolic syndrome	Low Testosterone (Men)	PCOS	Arthritis

Depression/Anxiety	Drug Abuse	History of current or past Alcohol Abuse	Bipolar Disorder	Eating Disorder	Glaucoma
Seizures	Anemia	Sleep Disorder/use of CPAP	Cancer	Gout	Stroke

Please list any additional health information that we should know about you:

_____

Has any **blood relative** ever had any of the following? Please circle

Unexplained death <40 years age	Heart Attack	Cancer	High Blood Pressure	Heart Disease/Stroke
Mental Illness	Diabetes or "borderline diabetes"	Overweight	Kidney Disease	Drug abuse
Alcohol abuse	Glaucoma	Asthma	High Cholesterol	

Exercise History (What you are doing right now)

Type: Walking Biking Swimming Other:_____

What is your frequency?	Your intensity?	How long?
☐None	☐None	☐ None
☐ 1-2 times weekly	☐ Light (Brisk walk, golf)	☐ under 10 minutes
☐ 3-5 times/week	☐ Moderate (Biking, aerobics)	☐ 10-20 minutes
☐ Daily	☐ Moderately hard (running)	☐ 20-30 minutes
	☐Very hard	☐ over 30 minutes

Do you perform any resistance type exercise (weight lifting or strength training)? Y N

Do you use a device to monitor your exercise (Fit Bit or Pedometer) ? Y N

Do you have or use a scale? Y N

Do you have any disabilities that effect your ability to exercise? Y N (Please Explain)

Behavior/Lifestyle: Which of the following best describes **you**? Please circle:

Lack of time for self	Stress eating	Eating late or waking up to eat	Eating too fast
Liquid calories such as excess alcohol or soda	Always hungry	Mindless eating/habit eating	Boredom eating
Food cravings (carbs)	Food dominate life	Eating so much uncomfortably full	Large Portions

Skipping meals	Social eating (only eat excessively at social events with friends)	Weekend overeating	Other:

•How would you rate your readiness for lifestyle changes to reduce your weight? Please circle:

✪ Low ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ✪High

•Are you willing to keep a food journal? Y N

•What is your main reason for wanting to lose weight? _____

•How confident are you that you can lose weight at this time?

✪ Low ◆ 1 ◆ 2 ◆3 ◆4 ◆5 ✪High

•How supportive is your **family** for your weight loss goals?

✪ Low ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ✪High

•How supportive are your **friends** for your weight loss goals?

✪ Low ◆ 1 ◆ 2 ◆ 3 ◆ 4 ◆ 5 ✪High

•Is your spouse, fiancé, partner, or children overweight? Y N If yes, who? _____

•How often do you eat out? Please circle: Rarely 1-2 times/week 3-5 times/week Daily

Please describe a typical day of food and drink for you?

How did you hear about us?