Mercy Health – Weight Management Solutions

MERCYHEALTH
Weight Management Solutions

ADULT MEDICAL DATA Date: _____

The more we know about you, the better medical care we can provide. This information will be kept strictly confidential. Please complete all pages.

Name: _____ Sex: M / F Marital Status: S M D W

Occupation: _____ Employer: _____

Email Address: _____ Birthdate: ____/____/____

Emergency Contact Name: _____ Relationship: _____

Phone #: _____ Address of Contact: _____

Primary Care Physician: _____ Phone #: _____

Referring Physician (if any and specialty): _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Have you contacted your insurance carrier regarding coverage for the Program? ☐ Yes ☐ No

Has your insurance coverage been verified by our department? ☐ Yes ☐ No

Will your Insurance Plan provide coverage for Obesity Treatment Services?* ☐ Yes ☐ No

*If *Yes*, please provide the following insurance information:

Insurance: _____ _____
Name of Contract Holder Relationship

_____ _____
ID/Contract # Group #

I authorize the release of any medical information necessary to process this claim:

_____ _____
Patient / Responsible Party Signature Date

YOUR MEDICAL INFORMATION

If necessary, will you accept a blood transfusion? ☐ Yes ☐ No Are you allergic to latex? ☐ Yes ☐ No

Are you taking aspirin or other blood thinners? ☐ Yes ☐ No Are you allergic to shellfish? ☐ Yes ☐ No

Allergies: (medication, foods, plants, etc. ***Please note type of reaction.***)

_____

_____

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Medical Problems:

	Hypertension (high blood pressure)		Diabetes, Type _____		Stroke (TIA)
	Hyperlipidemia (high cholesterol)		Congestive Heart Failure		Reflux (GERD)
	Coronary Artery Disease (heart)		Arrhythmia (irreg. Heart rate)		Asthma
	Atrial Fibrillation (A. Fib)		Emphysema (COPD)		Depression
	Hypothyroidism (low thyroid)		Anxiety disorder/panic attacks		Cancer, Type _____
	Polycystic Ovarian Syndrome		Arthritis, where _____		Migraine headaches
	Previous heart attack (MI)		Fibromyalgia		Seizure disorder
	Stomach Ulcer		Sleep apnea, on CPAP/BiPAP?		Back pain
	Previous DVT or PE (blood clot)		Liver disease		Kidney disease
	Urinary incontinence		Hernia, Type _____		Gout

List all others:

_____

_____

Current Medications: (prescriptions, patches, eye drops, birth control pills, over-the-counter remedies, pain relievers, laxatives, vitamins, etc.)

Medication and Purpose:	**Strength:**	**Number of times taken a day:**
List All Surgeries:	**When:**	**Where:**

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Blood Relative's Family Medical History
Please write in which relative, including grandparents, parents, brothers, sisters, children, etc. Please indicate maternal (mother's side) or paternal (father's side).

Hypertension (high blood pressure) _____
Hyperlipidemia (high cholesterol) _____
Coronary Artery Disease _____
Stroke _____
Diabetes _____
Cancer (type) _____
Blood clots _____
Migraine headaches _____
Seizure disorder _____
Alcoholism, Drug use _____
Mental illness, Depression _____
Emphysema (COPD) _____
Asthma _____
Kidney Disease _____
Arthritis _____
Glaucoma _____
Other: _____

Social History *(Estimate How Much You Use)*

Alcohol: _____

Tobacco: _____ Pack Per Day? _____ Years: _____

If you are a previous smoker: Quit date: _____ How Long: _____

Other Tobacco use: _____ Drug use: _____

Weight History / Body Mass Index

Current Weight: _____ Height: _____ Desired Weight: _____

BMI: _____ Highest Adult Weight: _____ Lowest Adult Weight: _____

Do you exercise? ☐ Yes ☐ No

If you do exercise, what do you do?

_____

How often? _____

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Previous Diet Attempts: *Please check all that apply.*

Diets:

	Atkins		Cabbage Soup
	Weight Watchers		The Zone
	Sutcamp		South Beach
	Richard Simmons		Nutritional Counseling with dietitian
	Personal Trainer		Hypnosis
	LA Weight Loss		Sugarbusters
	Diet Workshop		Metabolife/Herbalife
	Low fat diet		Calorie restriction
	Bloodtype		Low carb diet
	Grapefruit		Physician supervised diet
	Other _____		Other _____

Liquid Diets:

	Optifast
	Medifast
	Slimfast
	Physician's Weight Loss

Diet Medications:

	Alli
	Ephedrine
	Fen-phen
	Redux
	Meridia
	Adipex
	Dexedrine
	Xenical

Other: _____

_____

_____

_____

_____

Which ones have been in the past 12 months? _____

_____

_____

_____

_____

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24 HOUR DIET RECALL

Please list all foods and quantities eaten in a 24-hour period. Be precise in listing portions and provide time of day.

Breakfast

Snack

Lunch

Snack

Dinner

Snack