CHI Memorial

Imagine better health.℠

PATIENT HISTORY AND PHYSICAL FORM

***How did you hear about us*? _____**

PATIENT NAME: LAST_____ FIRST _____

DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY#: _____- _____- _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____-_____ WORK PHONE: (____) _____-_____ CELL PHONE (____) _____-_____

GENDER: [ ] MALE [ ] FEMALE RACE: [ ] BLACK [ ] HISPANIC [ ] WHITE [ ] OTHER_____

ETHNICITY: [ ] HISPANIC/LATINO [ ] NON-HISPANIC/LATINO MARITAL STATUS: [ ] S [ ] M [ ] D [ ] W

LANGUAGE: [ ] ENGLISH [ ] SPANISH [ ] OTHER _____

PRIMARY CARE PHYSICIAN: _____

EMPLOYMENT: [ ] FULL TIME [ ] PART TIME [ ] SELF [ ] NOT [ ] RETIRED [ ] MILITARY

EMPLOYER: _____ COLLEGE STUDENT: [ ] FULL TIME [ ] PART TIME [ ] NOT

EMAIL ADDRESS: _____@_____

GUARANTOR/RESPONSIBLE PARTY

Same as above ( )

LAST NAME: _____ FIRST NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: (____) _____-_____ SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

INSURANCE POLICYHOLDER INFORMATION

Same as above ( )

POLICY HOLDER: LAST NAME: _____ FIRST NAME: _____

SOCIAL SECURITY #: _____-_____-_____ DATE OF BIRTH: _____/_____/_____

RELATIONSHIP TO PATIENT: _____

EMERGENCY CONTACT: _____ _____ _____

NAME RELATIONSHIP PHONE NUMBER

Social History:

Do you smoke? Yes No How many packs per day? _____ Years smoked_____

Are you a former smoker? Yes No Year quit_____ Packs per day _____ Years smoked_____

Do you use vape or oral tobacco? Yes No

Do you drink alcohol? Yes No How frequently? _____

Do you use recreational drugs? Yes No How frequently? _____

What is your preferred learning style? _____

Surgical History: (If you need additional space to list surgeries, please let us know)

Surgery	Year	Surgeon	City, ST

Medical History:

Allergies: _____

Diabetes: Yes No Year Diagnosed: _____ Current A1C: _____

Oral Medications: Insulin Diet and Exercise Average Blood Sugar: _____

Hypertension: Yes No Treated with medications: Yes No Year diagnosed: _____

Heart Disease: Yes No Angina: Yes No Stroke: Yes No

Heart Attack: Yes No What year: _____ Congestive Heart Failure: Yes No

Have you ever undergone any testing on your heart? Yes No When? _____

High Cholesterol or Triglycerides: Yes No Blood Clot(s): Yes No

Sleep Apnea: Yes No Do you use a C-Pap machine or oxygen: Yes No

Have you undergone a sleep study? Yes No When? _____

Bone or Joint pain: Yes No Areas affected: _____

Currently taking pain medications or anti-inflammatory for condition: Yes No

Urinary Incontinence: Yes No Reflux or Heartburn: Yes No

Have you ever diagnosed with a hernia: Yes No Type: _____

Shortness of breath: Yes No Activity Included: Yes No

Other: _____

Family History:

Please list all medical conditions including obesity for the following family members

Mother:

_____

_____

Is your Mother still living? Yes No If no, what was the cause of death?_____ Age_____

Father:

_____

_____

Is your Father still living? Yes No If no, what was the cause of death?_____ Age_____

Siblings:

_____

_____

Weight History:

Please completely fill out the enclosed weight loss history form. You must include the last five years and list an approximate high weight for each year.

What has been your highest weight ever? _____ When? _____

How long have you been overweight? Years _____ Age _____

Current clothing size: Pants:_____ Shirt: _____ Dress: _____ Goal weight/size: _____

Have you previously had surgery in order to lose weight? Yes No

If yes, what procedure? _____

Year: _____ Surgeon: _____ Hospital: _____

Mental History:

Are you currently taking any drugs for depression or anxiety? Yes No

Are you currently being treated by a mental health provider? Yes No

If yes, for what reason: _____

Name of Physician or Therapist: _____

If you are currently seeing a mental health provider, a clearance letter from your doctor will be required.

Have you been treated in the past by a mental health provider? Yes No

What reason: _____

By signing the following form, I certify that the above stated information is true and complete to my understanding and knowledge.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY ***DATE***

Medication Name	Dosage	Frequency

Vitamins, over the counter medications, etc:

_____

_____

Pharmacy Name, City, State, Phone Number:

_____

_____

Allergies:

_____

_____

Weight Loss History

(Include at least the last 5 years)

Year	Weight	Weight Loss Efforts	Amount Lost	Amount Regained

Which diet have you been most successful with?

_____

How much did you lose on that diet?_____