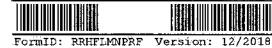
Lifestyle Medicine New Patient Registration Form

	rnysician ini	tormation	
PRIMARY CARE PHYSICIAN:			
CARDIOLOGIST:			
ENDOCRINOLOGIST:			<u>.</u>
OTHER RELEVANT SPECIALISTS:			
(pleas	<u>Medicatio</u> se include vitam	on <u>List</u> nins/supplements)	
Name of Medication (Please write clearly & check spelling)	Dose (mg, etc.)	Frequency (times/day, etc)	Reason for taking (diagnosis or condition)
	"		





Doc Type: Questionnaire, Page 1 of 4

New Patient Registration Form, Continued	New Patient Registration Form, Continued			
	Current Health Concerns			
This company is a day of important	fango			
List your current health concerns in order of impor	tance.			
	<u>Goals</u>			
What goals are you hoping to meet by working wit	h us?			
	Personal Health History			
•	reisonal ricatin riistory			
Please list any medication allergies along with their	r reactions:			
		—		
Please list any other allergies along with their reac	tions (food, bee sting, latex, etc.):			
Troube libe and other another around with another route				
	The second and the latest			
Please list any surgeries or hospital stays	Date of surgery/hospital stay			
Do you have a present or past	history of any of the following (check all that apply):			
III I DI Al D.	Rheumatoid Arthritis			
High Blood Pressure High Cholesterol	Osteoarthritis			
High Triglycerides	Osteoporosis			
Pre-Diabetes	Kidney Disease			
Diabetes	Non-alcohol fatty liver disease			
Metabolic Syndrome	Constipation			
Angina	Hemorrhoids			
Heart Attack	Gout			
Coronary Bypass	Gallbladder Disease			
Stent Placement	Cancer (type:			
Heart Failure	Bronchitis/Emphysema			
Abnormal EKG	Ulcers			
Blood Clotting Problem	Thyroid Disorder			
Irregular Heartbeat	Eating Disorder			
Stroke	Sleep problems			
Anxiety	Other			
Depression				

New Patient Registration Form, Continued	 		· · ·	
	<u>Health Habits</u>			
Do you smoke or use any tobacco products? Number of cigarettes each day? How many years? Other forms of tobacco used?	□Ÿes	□ No	□ Quit	
Do you drink alcohol? How much? How often?	□ Yes	□No	🛚 Quit.	
Caffeinated beverages? How much? How often? Which ones?	□ Yes	□.No.		
How many 8 oz. of water per day?				
How physically active are you? Type Frequency				
Describe your sleep habits:				
	Eating Habits			
Please indicate below how many se				
	1 piece medium fruit			
	leafy greens, ½ c all ot			
Whole grains like barley, brown rice, and quinoa. Potatoes (serving = 1)	(serving	$=\frac{1}{2}$ c cooked)	
Potatoes (serving = 1 medium baked or boiled, 1c mashed) Legumes like beans and lentils. (serving = ½ c cooked)				
Omega-3s like walnuts and flaxseeds.	(serving = ½ c nu			
	g = 1 egg; include thos			
Dairy		liquid or 2T s		
	= 3-4oz; about the size	of your palm)	
	g sizes vary; see packa	ges for details)	
White bread, white pasta, white rice			·	
Cakes, doughnuts, cookies				
Chips, pretzels	 			
Candy, chocolate Oil (used in dressings, for cooking, or baking)		(aai	IT	
The state of the s		(serving =)	11)	
	ow how many times pe	r week you:		
Eat meals prepared outside the home (restaurants, tak	ceout, etc.)			
Prepare meals at home		: · · · · · · · · · · · · · · · · · 		

New Patient Registration Form, Continued	
What are your favorite foods?	
What foods do you avoid?	
What roots do you arold:	
	Family History
Maternal Family Illnesses	
Maternal Family Member	Illness
Paternal Family Illnesses	
Paternal Family Member	Illness