ROCHESTER REGIONAL HEALTH | RRH Family and Lifestyle Medicine Canandaigua

# Lifestyle Medicine New Patient Registration Form

## Physician Information

PRIMARY CARE PHYSICIAN: ______________________________

CARDIOLOGIST: ______________________________

ENDOCRINOLOGIST: ______________________________

OTHER RELEVANT SPECIALISTS: ______________________________

## Medication List
(please include vitamins/supplements)

| Name of Medication (Please write clearly & check spelling) | Dose (mg, etc.) | Frequency (times/day, etc) | Reason for taking (diagnosis or condition) |
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## Current Health Concerns

List your current health concerns in order of importance.

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## Goals

What goals are you hoping to meet by working with us?

______________________________________________________________________

______________________________________________________________________

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## Personal Health History

Please list any medication allergies along with their reactions:

______________________________________________________________________

______________________________________________________________________

Please list any other allergies along with their reactions (food, bee sting, latex, etc.):

______________________________________________________________________

______________________________________________________________________

| 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):

| | | | |
|---|---|---|---|
| | High Blood Pressure | | Rheumatoid Arthritis |
| | 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 | | |

## Health Habits

Do you smoke or use any tobacco products? ☐ Yes ☐ No ☐ Quit
Number of cigarettes each day? _____
How many years? _____
Other forms of tobacco used? _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Quit
How much? _____
How often? _____

Caffeinated beverages? ☐ Yes ☐ No
How much? _____
How often? _____
Which ones? ____________________

How many 8 oz. of water per day? __________

How physically active are you?
Type __________
Frequency __________

Describe your sleep habits:
______________________________
______________________________
______________________________

Describe how you manage stress:
______________________________
______________________________
______________________________

## Eating Habits

Please indicate below how many servings (on average) of the following you eat daily:

| Food | Serving | |
|---|---|---|
| Fruits | (serving = 1 piece medium fruit or ½c chopped) | |
| Vegetables | (serving = 1c leafy greens, ½ c all other vegetables) | |
| Whole grains like barley, brown rice, and quinoa. | (serving = ½ 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 = ¼ c nuts or 2T seeds) | |
| Eggs | (serving = 1 egg; include those used in baking) | |
| Dairy | (serving = 1c liquid or 2T solid) | |
| Meat, poultry, fish | (serving = 3-4oz; about the size of your palm) | |
| Processed foods | (serving sizes vary; see packages for details) | |
| White bread, white pasta, white rice | | |
| Cakes, doughnuts, cookies | | |
| Chips, pretzels | | |
| Candy, chocolate | | |
| Oil (used in dressings, for cooking, or baking) | (serving = 1T) | |

Please indicate below how many times per week you:

| Activity | |
|---|---|
| Eat meals prepared outside the home (restaurants, takeout, etc.) | |
| Prepare meals at home | |

What are your favorite foods?

___

___

What foods do you avoid?

___

___

## Family History

### Maternal Family Illnesses

| Maternal Family Member | Illness |
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### Paternal Family Illnesses

| Paternal Family Member | Illness |
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