

PATIENT REGISTRATION FORM

Please Print

Last Name: _____ First: _____ M.I.: _____

Address: _____ City: _____

State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

DOB: _____ Marital Status: _____ Sex: _____

Social Security #: _____ Dr. License #: _____

Employed: Yes ____ No ____ Employer: _____

Employer Address: _____ Occupation: _____

Spouse's Name: _____ Employer: _____

Employer Address: _____ Work Phone: _____

Referred By: _____

Nearest Friend or Relative (not living with patient): _____

Address: _____

Relationship To Patient: _____ Phone: _____

How Did You Hear About Us?

Friend: _____ Newspaper (which one): _____

Physician (which one): _____ Postcard: _____

Radio _____ Other _____

I Will Be Paying Today By: _____ CASH _____ CHECK _____ CHARGE

I agree that I have come to Dr. R. Maurice Bonilla to assist me in losing weight. I understand that by joining the weight management program, I am committing myself to regular weekly visits for the purpose of monitoring my blood pressure, checking my food diary and supervising my eating habits so that I may lead a happier, healthier, life. I understand that I am agreeing to weekly visits, keeping a food diary, and that I will be responsible for full payment. Weekly visits are mandatory and account will be charged every week. I am looking forward to a thinner, happier, me and will commit to my share of the work ahead.

SIGNED: _____ DATE: _____

I hereby acknowledge that I have had the opportunity to review and ask questions about Dr. Bonilla's financial and privacy policies.

(continued on other side)

WEIGHT LOSS QUESTIONNAIRE

Name _____ Date _____

Please complete this questionnaire, which will help you and your physician develop the best management plan for you.

1. Is there a reason you are seeking treatment at this time?

2. What are your goals about weight control and management? _____

3. Your level of interest in losing weight is:
Not interested 1 2 3 4 5 Very interested

4. Are you ready for lifestyle changes to be a part of your weight control program?
Not really 1 2 3 4 5 Very ready

5. How much support can your family provide??
No support 1 2 3 4 5 Much support

6. How much support can your friends provide?
No support 1 2 3 4 5 Much support

7. What is the hardest part about managing your weight?

8. What do you believe will be of most help to assist you in losing weight?

9. How confident are you that you can lose weight at this time?
Not confident 1 2 3 4 5 Very confident

10. How confident are you that you can keep weight off at this time?
Not confident 1 2 3 4 5 Very confident

Weight History

11. As best as you can recall, what was your body weight at each of the following time points (if they apply)?
Grade School _____ High School _____ College _____ Ages 20-29 _____ 30-39 _____ 40-49 _____ 50-59 _____

12. At what age did you start trying to lose weight? _____

13. Please check all previous programs you have tried in order to lose weight. Include dates and your length of participation.

PROGRAM	DATE	WEIGHT (LOSS OR GAINED)	LENGTH OF PARTICIPATION
•TOPS	_____	_____	_____
•Weight Watchers	_____	_____	_____
•Overeaters Anonymous	_____	_____	_____
•Liquid diets (eg. Optifast)	_____	_____	_____
•Diet Pills; Meridia, Xenical	_____	_____	_____
•Diet Pills; Phen-fen, Redux	_____	_____	_____
•NutriSystems/Jenny Craig	_____	_____	_____
•OTC Diet Pills	_____	_____	_____
•Obesity Surgery	_____	_____	_____
•Registered Dietitian	_____	_____	_____
•Other	_____	_____	_____

14. Have you maintained any weight loss for up to 1 year on any of these programs? Yes No

15. What did you learn from these programs regarding your weight? _____

16. What did not work about these programs? _____

17. Have you been involved in physical activity programs to help with weight loss? Yes No

18. Are your children overweight? Yes No

(continued on next page)

WEIGHT MANAGEMENT HISTORY

Patient Name: _____ Date: _____

PERSONAL HISTORY ILLNESS:

Do you have or have you ever had:

- Pneumonia NO YES
Rheumatic Fever or
Heart Disease NO YES
Arthritis or Rheumatism NO YES
Gonorrhea or Syphilis NO YES
Anemia NO YES
Jaundice NO YES
Epilepsy/Convulsions NO YES
Tuberculosis NO YES
Diabetes NO YES
Cancer NO YES
High Blood Pressure NO YES
Liver Disease NO YES
Thyroid Disease NO YES

ALLERGIES:

**HISTORY OF ALCOHOL OR DRUG
ABUSE:** NO YES

WEIGHT:

Now: _____
One year ago: _____
Maximum: _____
When: _____

BLOOD TRANSFUSIONS:

NO YES

SURGERY:

SYSTEMS REVIEW:

EYES:

Seeing Double NO YES

EARS:

Hearing Loss NO YES
Infections NO YES
Ringing in Ears NO YES
Earache or Discharge NO YES

THROAT AND MOUTH:

Frequent Sore Throats NO YES

NECK:

Goiter NO YES
Lump or swelling NO YES

BREAST:

Lump NO YES
Discharge NO YES
Pain NO YES

HEART AND LUNGS:

Chronic Cough NO YES
Coughing Up Blood NO YES
Shortness of Breath NO YES
Night Sweats NO YES
Chest Pain or Pressure NO YES
Palpitations or Fluttering NO YES
Swollen Ankles NO YES

INTESTINAL:

Loss of Appetite NO YES
Trouble Swallowing NO YES
Nausea or Vomiting NO YES
Pain Abdomen NO YES
Bowel Habit Changes NO YES
Constipation NO YES
Diarrhea NO YES
Bloody Stool/Hemorrhoids NO YES

(continued on other side)

WEIGHT MANAGEMENT HISTORY (Cont'd)

KIDNEY, BLADDER AND GENITALS

Blood or Pus in Urine NO YES

Bladder or Kidney

Infection NO YES

Getting up night to urinate (_____)
times NO YES

MENSTRUATION:

(Women)

When was your last period?

NEUROLOGICAL:

Frequent Headaches NO YES

Dizzy Spells NO YES

EXTREMITIES:

Arthritis NO YES

Varicose Veins NO YES

Cramps in Legs NO YES

Earache or Discharge NO YES

GENERAL:

Unusual Fatigue NO YES

Unusual Weakness NO YES

Skin Trouble NO YES

Back Pain NO YES

HABITS:

Coffee _____ cups per day

Smoking:

Cigarettes: _____ packs per day

Alcoholic Beverages:

Present:

Light Moderate Heavy

Regular Exercise NO YES

MEDICATIONS:

Please list all medications:

Check off any of the dietary problem areas listed below that apply to you:

Meal Skipping

Carbohydrate craving

Large portions size

Too much alcohol

Frequent snacking

Eating foods too high in fat

Eating too many meals out in restaurants

Eating for reason other than hunger

Eating before going to bed

Do you ever binge on food? Yes No

Have you ever made yourself
vomit after meals? Yes No

Have you ever been treated
for Bulimia? Yes No

Have you ever been treated
for Anorexia Nervosa? Yes No

Any other information that may be helpful:

FAMILY HISTORY:

Father _____

Mother _____

Brother/Sister _____

HAS ANY BLOOD RELATIVE EVER HAD:

Cancer NO YES

Tuberculosis NO YES

Diabetes NO YES

Heart Trouble NO YES

High Blood Pressure NO YES

Bleeding Tendency NO YES

Stroke NO YES

Obesity NO YES