STEP AHEAD®
DOCTOR SUPERVISED WEIGHT LOSS CENTER

PATIENT INFORMATION

Patient Name: _____
(Last) (First) (MI)

Email Address: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular Phone: _____

Birthdate: _____ Age: _____ Sex: M F

Country of Birth: _____ Country of Parent's Birth: _____

Education: (Circle the highest level achieved)

Elementary High School/Technical School 2-yr College 4-yr College Graduate School

EMPLOYMENT INFORMATION

Patient Employer: _____

Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone : _____ Ext: _____

Social Security: _____

Driver's License: _____

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IN CASE OF EMERGENCY

Patient Name: _____

Emergency Contact Name: _____

Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

How did you hear about us? (Please specify)

_____ Newspaper
_____ Magazine
_____ Friend
_____ Other _____

FINANCIAL POLICY

Thank you for selecting Dr. Deborah L. Neiman for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, American Express and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

Patient's Signature _____ Date _____

Patient's Signature _____ Date _____

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HEALTH HISTORY

Name: _____ Today's Date: _____

Age: _____ Birthdate: _____ Date of last physical examination: _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking	**ALLERGIES** To medications or substances
Pharmacy Name_____ Phone_____	

HEALTH HISTORY PAGE 2

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates.

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed By _____ Date _____

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NUTRITION EVALUATION

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____

   _____

5. When did you begin gaining excess weight? (Give reasons, if known): _____

   _____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: _____

   _____

   Give dates and results of your weight loss: _____

   _____

   _____

8. How often do you eat out? _____
9. What restaurants do you frequent? _____
10. How often do you eat "fast foods?" _____
11. Who plans meals? Cooks? Shops? _____
12. Do you use a shopping list? Yes No
13. What time of day and on what day do you shop for groceries? _____
14. Food allergies: _____
15. Food dislikes: _____
16. Food you crave: _____

NUTRITION EVALUATION PAGE 2

17. Any specific time of the day or month do you crave food? _____

- Do you drink coffee or tea? Yes No How much daily? _____
- Do you drink cola drinks? Yes No How much daily? _____
- Do you drink alcohol? Yes No What? _____

  How much? _____ Weekly? _____
- Do you use a sugar substitute? _____ Butter? _____ Margarine? _____
- Do you awaken hungry during the night? Yes No
- What do you do? _____

18. What are your worst food habits? _____

19. Snack Habits: What? _____ How much? _____ When? _____

20. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

21. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

22. Typical Breakfast: time eaten, where, with whom? _____

23. Typical Lunch: time eaten, where, with whom? _____

24. Typical Dinner: time eaten, where, with whom? _____

25. Describe your usual energy level: _____

Activity Level: (answer only one)

_____ Inactive - no regular physical activity with a sit-down job.

_____ Light activity - no organized physical activity during leisure time.

_____ Moderate activity - occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

_____ Heavy activity - consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.

_____ Vigorous activity - participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

26. Please describe your general health goals and improvements you wish to make:

_____

_____