THE LIGHTER WEIGH

Thank you for choosing The Lighter Weigh for your weight management needs. We sincerely look forward to meeting you and working together to help you achieve your goals.

Location:
Our office address is 1 Hospital Drive SW, Suite 300 Huntsville AL 3580. We are located in the Crestwood Medical Center Medical Pavilion 2 and our building also has the Maternity Center, the Cancer Center and valet parking.

Directions:
Crestwood Medical Center is off Airport Road. Take Memorial Parkway South and exit on Airport Road. Turn left onto Airport Road. Go through 3 traffic lights and then turn left onto Hospital Drive. At the stop sign, cross over Whitesport Drive and continue to the main parking area. Our building is to the right. You have the option to valet park.

Here are a few things to know and have prepared for your first visit:

1) **New Patient Forms.** Please fill out the complete paperwork and forms in advance of your visit. It contains your medical history, weight history, consent forms, and a copy our "Privacy Policy" for your records. **We understand and appreciate that the forms and questionnaires are very detailed and will take about 20 minutes to complete. Please take the time to fill them out completely and accurately as this really helps us learn more about you so that we can better assist you during your visit.**

   If you can, **please fax your new patient forms to our office 3-7 days prior to your visit** as this will allow us time to transfer your information into our electronic medical record and allow us to review your chart prior to your visit. You may fax your paperwork to **(256) 429-9109.**

2) **Medication List.** Please make sure to bring all of your medication bottles or a pharmacy printout of your medications so that we may accurately record them in our chart.

3) **Labs.** If you have had blood work drawn in the last 3 months, please bring a copy to your 1st visit, or arrange for a copy to be faxed to our office. If not, **we can order any necessary labs. You may obtain these on the day of the visit, if you are fasting.** Labs may be drawn at a lab facility at your convenience.

4) **Payment.** Please note that full payment is required at the time of service. We accept cash, and all major bank cards. We do not accept checks.

5) **Please arrive 30 min prior to your scheduled appointment** so we can register you and start your visit on time.

6) **Fax New Patient Forms**. Again, if possible, please fax your completed New Patient Forms to **(256) 429-9109** in advance of your scheduled appointment.

Thank you and we look forward to meeting you!

New Patient Demographic Info

Patient Information	**Please Print all Information Clearly with a Black Pen**
Title	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
First, Middle, and Last Name	
Preferred / nickname if different from above	
Address Line 1	
City, State, Zip Code	
Phone Number(s) please star (*) your preferred phone number	Home ( )
	( ) Cell
	Work ( )
Okay to leave a message on home phone?	**no yes** Okay to leave a message on cell phone? **no yes**
E-mail address	
Birthday (mm/dd/yyyy)	Age:
Your Occupation	
Employer Name	
Marital Status (Circle one)	Single Married Engaged Partnered Divorced Widowed
Spouse's Name	
Spouse's Occupation	
Who lives in the Household with you?	
Your Children's Ages & Names:	
Primary Care Provider's Name and Number	
Names of your other Physicians	
How did you hear about us? (Circle One)	Friend Website Physician DEW Center Other
Pharmacy Information	
Pharmacy Name	
Pharmacy Phone Number	
Pharmacy Street Address (or street name)	
Pharmacy City / State / Zip	
Emergency Contact Information	
First and Last Name and Relationship	
Phone Number(s)	

New Patient Medical History

Medications	
List all prescription medications & doses below	**List all Over-The-Counter and Dietary Supplements**
please include method of birth control (i.e. OCPs or IUD)	
☐ check here for "no prescription medications"	☐ check here for "no OTC meds or dietary supplements"

Allergies to Medications (list drug name and allergic reaction below)	
☐ check here for "no allergies"	

Medical Conditions and Surgeries			
Do have a history of any of the following conditions?			**List any OTHER MEDICAL CONDITIONS below:**
High Blood Pressure	**no**	**yes**	
High Cholesterol	**no**	**yes**	
Diabetes	**no**	**yes**	
Personal history of Heart Disease	**no**	**yes**	
Previous heart attack or stent?	**no**	**yes**	

Previous heart surgery (bypass?)	**no**	**yes**	
Stroke / TIA	**no**	**yes**	
PCOS (polycystic ovary syndrome)	**no**	**yes**	
Low Thyroid (Hypothyroidism)	**no**	**yes**	
Migraine Headaches	**no**	**yes**	**List any previous SURGERIES below:**
Sleep Apnea	**no**	**yes**	check here for "no previous surgeries"
If so do you use a CPAP machine?	**no**	**yes**	
Depression	**no**	**yes**	
Anxiety	**no**	**yes**	
Asthma / Emphysema / COPD	**no**	**yes**	
Eating Disorder (anorexia / bulimia)	**no**	**yes**	
Glaucoma	**no**	**yes**	

Social History			
Smoking History	☐ I've never smoked		
	☐ I previously smoked but quit		
	☐ I currently smoke the following # of packs per day:		
Alcohol Use	☐ I do not drink any alcohol		
	☐ I previously drank but quit History of alcoholism?	**no**	**yes**
	☐ I currently drink alcohol. How many drinks per week?		
Drugs / Illicit Substances	Have you ever given yourself street drugs with a needle?	**no**	**yes**
	Do you have a history of any drug addiction?	**no**	**yes**
	Are you currently using any street/illicit drugs?	**no**	**yes**
Sexual / Reproductive History	Are you sexually active?	**no**	**yes**
	If yes, are you currently trying to become pregnant?	**no**	**yes**
	If not trying to conceive, what contraceptive method?		
	Is there a possibility that you are pregnant right now?	**no**	**yes**
	Do you have a history of infertility?	**no**	**yes**
	When was your last menstrual cycle?		
	How many menstrual cycles do you have per year?		

Family History (list family members below with each of the following conditions)	
Indicate who in your family have any of the following medical conditions: (e.g. mother, father, brother, sister, children, cousins, uncles, aunts, grandparents)	Cancer (list types):
	Diabetes:
	Heart Disease:
	High Blood Pressure:
	High Cholesterol:
	Hypothyroidism/Low Thyroid:
	Sudden Death (age < 40):
	Other Family Conditions:

Review of Systems (please circle if you have any of the following)				
General	Fatigue	Change in weight	Always Cold	Always Hot
Heart	Chest Pain	Palpitations	Leg Swelling	
Lungs	Shortness of Breath	Coughing	Wheezing	
Abdomen	Nausea / Vomiting	Constipation	Diarrhea	
Menstrual	Irregular Cycles	No Menstrual Cycles	Post-Menopausal	
Mental Health	Depression	Anxiety	Trouble Sleeping	
Skin	Hair Loss	AcneExtra	Facial Hair	
Neurological	Headaches	Numbness/Tingling		

Life Milestones/Events & Weight

In the space provided, share any life events that relate to your weight loss or weight gain. Add any specifics you would like. *Possible life events may include: Special occasions/events (e.g., wedding, baby, class reunion, vacation), Home or work changes (eg job change, divorce, personal loss, move), Health or medical changes (e.g. nutritionist, injury, surgery, medication)*

When did this occur? (age)	Event	How much weight did you lose/gain?	Weight Loss	
			What did you do to lose weight?	Would you do it again? (Y/N)
__ years old		Lost___ lbs /Gained ___lbs		
__ years old		Lost___ lbs /Gained ___lbs		
__ years old		Lost___ lbs /Gained ___lbs		
__ years old		Lost___ lbs /Gained ___lbs		
__ years old		Lost___ lbs /Gained ___lbs		
__ years old		Lost___ lbs /Gained ___lbs		

Weight-Loss/Management Efforts

How would you describe your efforts to lose or maintain weight? Please select all that apply.

Current Efforts	Tried it in the past	Doing it now
Physical Activity	□	□
Healthy Eating	□	□
Over-the-Counter Products	□	□
Prescription Medication	□	□
Commercial Weight-Loss Programs (e.g. Weight Watchers)	□	□
Bariatric Surgery	□	□

How long have you been trying to lose weight?

Less than 2 years □	2-4 years □	5-9 years □	As long as I can remember □

Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)					
Meal	**Main Dishes**	**Side dishes**	**Desserts**	**Drinks**	**Eating Out / Restaurants**
Breakfast					# breakfasts out/week & where?
Morning Snacks					
Lunch					# lunches out/week & where?
Afternoon Snacks					
Dinner					# dinners out/week & where?
Evening Snacks					

How many breakfasts do you skip per week?	Why?
How many lunches do you skip per week?	Why?
How many dinners do you skip per week?	Why?
How many meals per week do you eat out or take out (Including breakfast, lunch, and dinner)?	
Which restaurants do you usually eat out or take out at?	
Do you frequently eat overnight?	☐ No ☐ Yes, I eat overnight
Do you consider yourself a stress eater?	☐ No ☐ Yes, I eat when I'm stressed
Do you feel hungry all the time?	☐ No ☐ Yes, I'm always hungry

Activity and Exercise Please select your current activity level (select only one of the options)	☐ Heavy Activity - regular exercise at least 3x per week ☐ Vigorous Activity - extensive exercise > 60 min at least 4x/week ☐ Inactive - no regular physical activity with a sit down sedentary job ☐ Moderate Activity - i.e. occasionally walk, jog, run, bike, golf, tennis

Outside of work and working in the home, please describe what physical activity you do and how often:

Do you do any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)?

What limits or prevents you from participating in more physical activity or exercise (e.g. joint problems, arthritis, time)?

Do you have membership at any gyms or exercise facilities? Which one(s)?

Behavior Styles, Stress, and Sleep Hygiene

Behavior Style (select only one of the options)	☐ You are calm and easygoing ☐ You are sometimes calm but frequently impatient ☐ You are seldom calm and have overwhelming drive for ambition ☐ You are hard driving and can never relax
Please circle your **STRESS** level:	**0 1 2 3 4 5 6 7 8 9 10** 0=no stress 5=moderate stress 10=extreme stress

Please describe major sources of stress in your life and how they affect you:

Sleep Hygiene and Sleep Patterns (select all that apply)	* What time do you usually go to sleep? * What time do you usually wake up? * Do you wake up through the night? □ no □ yes * Do you wake up and eat overnight? □ no □yes
	☐ I usually sleep 8 or more hours per night ☐ I usually sleep 6 - 8 hours per night ☐ I usually sleep 4 - 6 hours per night ☐ I usually sleep < 4 hours per night
	☐ I snore heavily at night ☐ I wake up in the morning still tired Have you ever had a sleep study? ☐ no ☐ yes I have sleep apnea; if yes do you use CPAP? ☐ no ☐ yes ☐ I work at night and sleep during the day