Byers Wellness Center- Patient Information for HCG Program

Welcome to Byers Wellness Center. We are excited to have you as one of our patients. In order for us to best serve you on your initial visit we ask that you complete this information and send it to us prior to your appointment time. You may fax this information to us at (770) 387-3425 or send via email to byerswellnesscenter@hotmail.com. If you have any questions, please don't hesitate to call us at (770) 387-3450.

General Patient Information

Patient's Name:		Date:
Address:		
City:	State:	Zip:
Date of Birth:	Social Security #:	
Home Phone: ( )	Cell Phone: ( )	
Email Address:		
Marital Status:		
Spouse's Name:		
Patient Employed By:		
Employer Address:		
How did you hear about us?		
In case of emergency, whom should we notify?		
Relationship to Patient?	Phone Number: ( )	

PERSONAL HEALTH HISTORY/STATUS

Are you in good health at the present time to the best of your knowledge? YES NO
Are you under a doctor's care at the present time? YES NO
If yes, please explain: _____
_____
Are you taking any medications, over the counter drugs, natural supplements or vitamins at the present time? YES NO
What: _____ Dosages:_____
What: _____ Dosages:_____
What: _____ Dosages:_____
What: _____ Dosages:_____
Any allergies to medications? YES NO
If yes, please list medications and effects(i.e. hives, shortness of breath, etc.)
_____
_____
_____
Do you have a history of high blood pressure? YES NO
Do you have diabetes? YES NO
If yes, at what age were you diagnosed? _____
Do you have a history of heart attack or chest pain? YES NO
Do you have shortness of breath? YES NO
Do you have a history of swelling feet? YES NO

Do you experience frequent headeaches? YES NO
Migraines?
Dizziness?
Fatique?
Do you have a history of constipation or difficulty with bowel movements? YES NO
Do you have a history of glaucoma? YES NO

Gynecological History: FOR WOMEN ONLY

Pregnancies:
Number of Pregnancies: _____ Dates:_____
Natural Delivery or C-Section (specify):_____
Menstrual :
Age of Onset: _____ Number of menses per year: _____
Duration : _____days
Are they regular: YES or NO
Pain associated: YES or NO
Last Menstrual Period: _____
Are you currently using any Hormone Replacement Therapy?
If yes, what kind: _____
Are you currently taking birth control pills?
If yes, what type:_____
Date of last gynecological checkup: _____

Are you experiencing abnormal hair growth? YES NO
Are you experiencing hair loss? YES NO
Have there been any recent changes in your sexual drive? YES NO
If yes, explain:_____
Have you experiencing any serious injuries? YES NO
If yes, explain:_____ Date:_____
Please list any surgeries you have had:
_____Date:_____
_____Date:_____
_____Date:_____

FAMILY HISTORY

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative every had any of the following:

Glaucoma: YES NO Who:_____
Asthma: YES NO Who:_____
Epilepsy: YES NO Who:_____
High blood pressure: YES NO Who:_____
Kidney disease: YES NO Who:_____

Diabetes:	YES	NO	Who:_____
Tuberculosis:	YES	NO	Who:_____
Psychiatric Disorder:	YES	NO	Who:_____
Heart Disease/Stroke:	YES	NO	Who:_____
Alcoholism:	YES	NO	Who:_____

PAST MEDICAL HISTORY(CHECK ALL THAT APPLY)

____ Polio	____ Measles	____ Tonsillitis
____ Jaundice	____ Mumps	____ Pleurisy
____ Kidney Disease	____ Scarlet Fever	____ Liver Disease
____ Lung Disease	____ Whooping Cough	____ Chicken Pox
____ Rheumatic Fever	____ Bleeding Disorder	____ Nervous Breakdown
____ Ulcers	____ Gout	____ Thyroid Disease
____ Anemia	____ Heart Valve Disorder	____ Heart Disease
____ Tuberculosis	____ Gallbladder Disorder	____ Psychiatric Illness
____ Drug Abuse	____ Eating Disorder	____ Alcohol Abuse
____ Pneumonia	____ Malaria	____ Typhoid Fever
____ Cholera	____ Cancer	____ Blood Transfusion
____ Arthritis/Joint Pain	____ Osteoporosis	____ Dry Skin
____ Depression	____ Mood Swings	____ Heartburn
____ Nausea/vomiting	____ Frequent colds/viruses	____ Increase in skin tags
____ Hypoglycemia	Other: _____	

NUTRITION EVALUATION

Present Weight: _____ Height(no shoes):_____ Desired Weight:_____
In what time frame would you like to be at your desired weight? _____
Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
What is the main reason for your decision to lose weight?
_____
When did you begin gaining excess weight? (Give reasons if known)
_____
_____
What has been your maximum lifetime weight (non pregnant) and when? _____
What previous diets have you followed: Give dates and results of your weight loss:

_____	_____
_____	_____
_____	_____
_____	_____

What was the toughest hurdle for you during your last weight loss attempt?
_____
_____
Have you found it difficult to lose weight even with exercise? YES or NO

What were some of the most important things that you learned during your last weight loss attempt?

_____

_____

_____

Is your spouse, fiancée or partner overweight? YES or NO
If yes, how much is he or she overweight? _____
How often do you eat?

_____

_____

What restaurants do you frequent?

_____

How often do you eat "fast foods"? _____
How often do you eat fruits and vegetables? _____
Who plans your meals? _____ Cooks? _____ Shops?_____
Do you use a shopping list? YES or NO
What time of day and on what day do you shop for groceries? _____
Do you have any food allergies?

_____

What foods do you dislike?

_____

What foods do you normally crave?

_____

Are you hungrier when you eat breakfast? YES or NO
Do you find it difficult to stop eating starches and sweets once you start? YES or NO
Any specific time of the day or month do you crave food? (ie: close to period)

_____

Do you drink coffee or tea? YES or NO How much daily? _____
Do you drink sodas? YES or NO How much daily?_____
Do you drink alcohol? YES or NO
What? _____ How Much?_____ How often?_____
Do you use a sugar substitute? _____ Butter? _____ Margarine?_____
Do you awaken hungry during the night? YES or NO
Are you hungrier when you eat starches? YES or NO
Do you awaken with a headache when you have eaten starches and/or sweets the day before? YES or NO
What are your worst food habits?

_____

_____

What do you typically snack on? _____
How much? _____ When?_____
When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

_____

_____

_____

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

_____

_____

_____

Do you eat because you are hungry or for comfort?

_____

Smoking Habits: (answer only one)
___ You have never smoked cigarettes, cigars or pipes.
___ You quit smoking ___ years ago and have not smoked since
___ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke
___ You smoke up to 20 cigarettes per day (1 pack).
___ You smoke up to 30 cigarettes per day (1 – ½ packs).
___ You smoke up to 40 cigarettes per day (2 packs).

Describe Your Typical Meals

Breakfast:	Lunch:	Dinner:
Time Eaten: _____	Time Eaten: _____	Time Eaten: _____
Where: _____	Where: _____	Where: _____
With Whom:_____	With Whom:_____	With Whom:_____

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.

Behavioral Style: (answer only one)
___You are always calm and easygoing.
___You are usually calm and easygoing.
___You are sometimes calm with frequent impatience.
___You are seldom calm and persistently driving for advancement.
___You are never calm and have overwhelming ambition.
___You are hard driving and can never relax.

Do you have trouble sleeping? YES or NO
If yes, how long have you had trouble sleeping? _____
How often do you have trouble sleeping? _____ nights per week
How does this affect you during the day?
_____
Do you sleep restlessly? YES or NO
Do you snore loudly? YES or NO
Please describe your general health goals and improvement you wish to make:
_____
_____
_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Signature: _____ Date: _____