NAME : _____

ADDRESS : _____

TELEPHONE : _____ STATUS : _____

BIRTHDATE : _____ SEX : _____

NEXT OF KIN : _____

ADDRESS : _____

TELEPHONE : _____ RELATIONSHIP : _____

ALLERGY TO MEDICINE : _____

PHARMACY : _____

MEDICARE # : _____

CONFIDENTIAL HEALTH RECORD

Name _____ Date of Birth _____ Sex _____
First Last

Permanent Home Address _____
Street City State Zip Code

In Case of Emergency Notify _____ ( ) _____
Name Area Code Phone Relationship

Address _____
Street City State Zip Code

Family Physician _____ ( ) _____
Name Street City State Area Code Phone

ALLERGIES/DRUG, OTHER

❒ Aspirin ❒ Animal ❒ Codeine ❒ Insect
❒ Penicillin ❒ Food ❒ Pollen ❒ Sulfa
❒ Other (please specify) _____

FAMILY MEDICAL HISTORY

If any of your blood relatives had the diseases listed, check in the space provided (include parents, grandparents, brothers, sisters).

❒ Alcoholism M F ❒ Mental Illness ❒ Heart disease M F
❒ Anemia ❒ Migraine ❒ Hereditary disease
❒ Bleeding tendency ❒ Obesity M F ❒ High blood pressure
❒ Tuberculosis ❒ Stroke M F ❒ None of the above
❒ Cancer ❒ Diabetes M F
❒ Breast ❒ Ovarian ❒ Lung M F ❒ Prostate
❒ Other (please specify) _____

DISABILITY

Do you consider yourself handicapped or disabled in any way that requires you to receive special consideration? If so, please check the appropriate box and give specifics.

❒ Vision ❒ Emotional
❒ Hearing ❒ Learning
❒ Locomotion ❒ Others (please specify)
❒ Other Motor _____

Please explain disability _____

List any medications you take on a regular basis:

List any condition currently under treatment: _____

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

❒ Acne (under treatment)
❒ Acquired Immune Deficiency Syndrome
❒ Alcohol or Drug Problem
❒ Anemia
❒ Anorexia Nervosa
❒ Anxiety
❒ Arthritis
❒ Asthma
❒ Back Problems
❒ Binge Eating
❒ Bladder Infection
❒ Bleeding Trait
❒ Blood Disorders
❒ Bulimia
❒ Cancer/Malignancy
❒ Cerebral Palsy
❒ Chlamydia
❒ Chronic Bronchitis
❒ Chronic Inflammatory Bowel Disease
❒ Chronic Tonsillitis
❒ Colds (frequently)
❒ Condyloma (genital warts)
❒ Crohn's Disease
❒ Depression
❒ Dermatology Problems
❒ Diabetes
❒ Diarrhea (recurrent)
❒ Digestive Troubles
❒ Dizziness/Fainting
❒ Eye Problem
❒ Gonorrhea
❒ Hayfever/Allergies
❒ Headaches (recurrent)
❒ Head Injury
❒ Heart Condition
❒ Heart Murmur
❒ Herpes Virus
❒ Hypertension (high blood pressure)
❒ Infectious Mononucleosis
❒ Insomnia
❒ Joint Disease or Injury
❒ Kidney Infection
❒ Kidney Stones
❒ Menstrual Cramps
❒ Menstrual Disorders
❒ Migraine
❒ Multiple Sclerosis
❒ Muscular Dystrophy
❒ Obesity
❒ Pelvic Infection
❒ Peptic Ulcer
❒ Phlebitis
❒ Pregnancy
❒ Prostatitis
❒ Psoriasis
❒ Rheumatic Fever
❒ Rheumatoid Arthritis
❒ Scarlet Fever
❒ Seizure Disorder/Epilepsy
❒ Sinusitis
❒ Syphilis
❒ Systemic Lupus Erythematosus
❒ Thyroid (overactive)
❒ Thyroid (underactive)
❒ Ulcerative Colitis
❒ Vaginitis
❒ Viral Hepatitis
❒ Worry or Nervousness
❒ Other (please specify)

_____
_____
_____

❒ Surgery (specify type)

_____
_____
_____

Signature _____ Social Security No. _____

NAME: _____

Ht. _____ Wt. _____ Age _____ Smoke: ❑ No ❑ Yes Packs per day: _____

Family History: Mom: L / D / Age _____
Diseases: ❑ Hi BP ❑ Diabetes ❑ Heart Dis. ❑ Cancer ❑ Organ _____
Dad: L / D / Age _____
Diseases: ❑ Hi BP ❑ Diabetes ❑ Heart Dis. ❑ Cancer ❑ Organ _____

Over-weight Relatives: ❑ Mom ❑ Dad ❑ GM ❑ GF ❑ Brother ❑ Sister

Your past medical history: ❑ Rheumatic Fever ❑ Diabetes ❑ Thyroid ❑ Hi BP
Kids _____ P _____ G _____ MC _____

Your past surgical history: ❑ T&A ❑ Appy ❑ GB ❑ Tubal ❑ C-Sect. ❑ Hyster ❑ Back ❑ Knee

FOOD ENEMIES:
1. ❑ Chocolates ❑ Ice Cream
2. ❑ Cookies ❑ Cakes ❑ Pastries
3. ❑ Hamburgs ❑ Steaks ❑ Fast Foods ❑ Chicken Wings ❑ Pizza ❑ French Fries
4. ❑ Bread ❑ Butter ❑ Potatoes ❑ Sour Cream

FLUIDS YOU DRINK:
1. ❑ Water ❑ Tea ❑ Coffee ❑ Cream (No Fat) ❑ Milk: ❑ 1% ❑ 2% ❑ Skim
❑ Sugar ❑ Equal ❑ Sweet n Low
2. ❑ Pop: ❑ Reg. ❑ Diet
3. ❑ O.J. (180) ❑ Cranberry (240) ❑ Grapefruit (130) ❑ Grape Juice (240) ❑ Apple Juice (180)

SOCIAL DRINKS: ❑ No
1. ❑ Beer: ❑ Lite ❑ Reg.
2. ❑ Wine: ❑ Chardonnay ❑ Cabernet ❑ Chablis ❑ Bianco ❑ Lambrusco
3. ❑ Liquor: ❑ 7&7 ❑ Vodka-Tonic ❑ Gin & Tonic ❑ Fuzzy Navel ❑ Kahlua & Cream

Salt User: ❑ No ❑ Mild ❑ Medium ❑ Heavy

Salad Dressing: ❑ Regular ❑ Diet: ❑ Just 2 Good ❑ Walden Farms ❑ Other _____

EXERCISE: ❑ Walk ❑ Run ❑ Bike ❑ Treadmill ❑ Stepper ❑ Ab-Roll
❑ CardioGlide ❑ Other _____

Your Normal Supper Time: _____ PM Your Normal Bedtime: _____ PM/AM ❑ 2nd ❑ 3rd Shift

Your Weight: Senior in High School _____ Married Wt. _____ Usual Wt. _____ Goal _____

Other Diet Programs Tried: ❑ Weight Watchers ❑ TOPS ❑ Nutra Systems ❑ Phy. Wt. Loss

Do you know your recent values for your: Sugar _____ Chol _____ HDL _____ Trig _____ Thy _____

My Obesity Boards require yearly chemistry profiles. Bring copies of last year's.

Are you jittery or nervous from Caffeine in coffee or pop? ❑ Yes ❑ No

Thank you for the time to fill this out!! We hope you enjoy your lost baggage!!!

Letter of Commitment

I _____ wish to participate in Dr. Allison's weight loss program. I realize that losing weight helps to lower blood pressure, reduce orthopedic stresses, keep diabetes in line, and helps lower cholesterol which helps lower heart disease and stroke.

I realize that such participation involves a total commitment on the part of myself in order to achieve a reasonable degree of weight loss and weight maintenance. I must remove my old eating habits and acquire new eating habits by learning better nutrition, eliminating fats, eating low cholesterol and low fat foods, and exercising. I will participate in regular exercise sessions and take medication only as prescribed. A sedentary life-style is as bad for me as is cigarette smoking.

In return, Dr. Allison promises to offer medical supervision on a monthly basis, dietary support, and talk with me about behavior modification.

I realize this is an on going endeavor of indefinite duration and I am committed in participating in such a program. This program may go beyond the length of time the FDA has indicated diet medications to be used. I feel that being over weight is of more harm to myself.

I also realize that weight loss programs are generally not covered under insurance policies. Therefore, I agree that visits to Dr. Allison are my sole financial responsibility. Failure to pay for such visits will result in my expulsion from the program.

If you desire to have other problems diagnosed and treated during your nutritional visit, an additional charge will be generated.

INITIAL

Signature _____

Date _____