# OCPA Health and Wellness New Patient Information

***Please print and bring completed form to your appointment. If unable to print form, then it will be necessary to come 30 minutes early to complete the forms prior to your consultation.***

**Patient Information**

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Gender:_____ SSN:_____

Height: _____ Weight:_____ BMI: _____ Desired Weight: _____

Address:_____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell:_____

Email:_____ Marital Status: Single/Married/Divorced/Separated/Widowed

Employer/School: _____ Occupation: _____

Referred by: _____ Last Menstrual Period (if applicable): _____

**If Patient is Under 18:** Name of Parent/Guardian: _____

**Emergency Contact**: _____ Phone: _____

Relationship:_____

**Primary Care Physician**: _____ Phone: _____

Fax: _____Date of Last Consultation:_____

**Insurance Information:**

Insurance Provider: _____ Phone:_____

Member ID #:_____ Group #: _____

Effective Date: _____ Authorization #:_____

**Medical History:**

| Problem | Self | Family | Describe/Comments |
|---|---|---|---|
| Acid Reflux | | | |
| Asthma | | | |
| Angina (Chest pain) | | | |
| Anxiety | | | |
| Arthritis | | | |
| Attention Deficit Disorder | | | |
| Aids or HIV | | | |
| Alcohol Abuse | | | |
| Autoimmune Problems | | | |
| Deep Vein Thrombosis | | | |
| Cancer | | | |
| Colitis | | | |
| Constipation | | | |
| Depression | | | |
| Diabetes | | | |
| Diarrhea | | | |
| Drug Abuse/Use | | | |
| Eating Disorder | | | |
| Fatty Liver | | | |
| Gallstones | | | |
| Glaucoma | | | |
| Gout | | | |
| Headaches/Migraines | | | |
| Heart Disease | | | |
| High Blood Pressure | | | |
| High Cholesterol | | | |
| Hot Flashes (Menopause) | | | |
| Insomnia | | | |
| Irregular menses | | | |
| Infertility | | | |
| Joint Pain | | | |
| Kidney Problems | | | |
| Liver Problems/Hepatitis | | | |
| Polycystic Ovarian Disease | | | |
| Seizures/Epilepsy | | | |
| Shortness of Breath | | | |
| Skin Disorder | | | |
| Sleep Apnea | | | |
| Smoking | | | |
| Stomach Ulcers | | | |
| Stroke/TIAs | | | |
| Stress Incontinence | | | |
| Swelling of Hands/Feet | | | |
| Thyroid Problems | | | |
| Urinary Stress Incontinence | | | |
| Other | | | |

**Surgical History:**_____ _____

Have you had Gastric Bypass or Lap Band surgery for weight control? _____

**Medications:**

Medication Name Dosing Frequency Taken For What Condition

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Non Prescription Medications:**

Medication Name Dosing Frequency Taken For What Condition

_____

_____

_____

_____

**Allergies to Medications:**_____

**Allergies to foods:**_____

**Social History:**

How many Alcoholic drinks do you drink per day or week? _____

How many Cigarettes do you smoke per day or week? _____

Have you ever been in any substance abuse treatment program/rehab of any kind?

**Health Management History:**

Desired health goals (feel better, weight loss expectations, diabetes, hypertension, cholesterol, fatigue, eating disorders, etc):

_____

Who is your main support: _____

**Exercise Regimen:**

How often do you exercise: _____

Exercise Activities: _____

Activity Level (please circle one): Light Moderate Heavy Vigorous

**Eating Behaviors:**

Which of the following contributed to your current weight? (circle those that apply):

Activity Changes/Lack of Exercise Age Childbirth Cravings Depression
Emotional Eating Genetics Injury Medical Condition Medications Menopause
Overeating Poor Food Choices Smoking Cessation Socializing Stress Time
Constraints Surgery Finances Other: _____

Previous weight loss attempts, including reason for success or failure:

_____

_____

_____ _____

**Patient Signature/Parent if minor** **Date**