Erlanger Metabolic Center
979 East Third Street, Suite C620
Chattanooga, TN 37403
Phone 423-778-2906 Fax 423-778-9482

PATIENT DEMOGRAPHIC SHEET

Patient Name_____ Birth Date_____ Sex: M F

SSN_____-_____-_____ Marital Status: M S D W O Race:_____

Address _____ City_____ State_____ Zip_____

Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____

Please circle your preferred method of contact: phone text message email Mychart

Is it okay to leave a message regarding medications, labs, appointments, or instructions? Yes No

Is it okay to text a message for reminder of appointments? Yes No

Email address:

_____

INSURANCE INFORMATION

Primary Insurance_____

Employer Of Insured:_____

Subscriber name: (if not patient)_____

Relationship_____ DOB_____ SSN_____-_____-_____

Insurance ID/Policy ID: _____ Group # _____

Secondary Insurance (if applicable)_____Subscriber (if different)_____

Relationship_____ DOB_____ SSN_____-_____-_____

Insurance ID/Policy ID: _____ Group # _____

Employer Of Insured: _____

EMERGENY CONTACT

Name:_____ Relation to contact:_____

Phone: Home: (____)_____-_____ Cell: (____)_____-_____ Work: (____)_____-_____

Full Address: _____

Is it okay to leave a message regarding medication, labs, appointments, or instructions? Yes___ No___

PHYSICIAN INFORMATION

Primary care physician: _____ Referring physician: _____

How did you hear about our office?_____

Have or a family member attended a Metabolic Milestone event? No ___ Yes ___

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Name:_____ Date of Birth: _____

Date of Visit: _____

Referring Provider: _____

Reason for Visit: _____

Please list below all Healthcare Providers who have treated you in the last 5 years

Provider (MD, DO, NP, PA)	Address	Phone
PCP:		
Cardiologist:		
Pulmonologist:		
Neurologist:		
Mental Health:		
OB/GYN:		
Pain Management:		
Surgeon:		
Other:		
Other:		

Allergies and Restrictions

Drug (medication allergies):	**Contact Allergies:**	**Dietary Restrictions:**
Drug Name Reaction _____ _____ _____ _____ _____ ☐**I have no drug allergies**	☐Latex ☐adhesive tape ☐Other: ☐**I have no contact allergies** **Food Allergies:** Food Reaction _____ _____ ☐**I have no food allergies**	☐Vegetarian ☐Vegan ☐Kosher ☐Lactose intolerant ☐Gluten ☐Other: ☐**I have no dietary restrictions**

Pharmacy of Choice Contact Information:

_____

_____

_____

_____

Medication: (list all medicine including doses and how often you take; include over the counter)

Drug	Dose	How often each day?	Why do you take this medication?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

Medical History: Have you been told you have any of the following?

	Anemia: type:_____		Glaucoma		PVD (peripheral vascular disease)
	Angina		Heart disease		Schatzki's ring
	Anxiety		Hepatitis: type: _____		Schizophrenia
	Arthritis: type: _____		Hernia: location: _____		Seizures
	Asthma		Hyperlipidemia (high cholesterol)		Sleep apnea
	Barret's esophagus		Hyperparathyroidism		Stroke (CVA)
	Bipolar disorder		Hypertension		Thyroid disease (high/low)
	Borderline personality		Infertility		TIA
	Cancer: type: _____		Inflammatory bowel disease		Urinary incontinence
	Celiac disease		Irritable bowel disorder		Varicose veins
	Congestive heart failure		Irregular heart beat		Vitamin D deficiency
	Cholelithiasis		Intertrigo (skin fold rash)		Other:
	Chronic constipation		Joint pain		
	Chronic diarrhea		Kidney disease		
	Chronic lung disease		Kidney stones		
	Cirrhosis		Leg ulcers		
	Clotting disorder		Liver disease (fatty liver)		
	COPD		Low back pain		
	Coronary artery disease		Migraines		
	Deep vein thrombosis		Morbid obesity		
	Depression		Myocardial infarction		
	Diabetes mellitus type 1		Nerve/muscle disease		
	Diabetes mellitus type 2		Obesity		
	Diabetes with complications		Osteoporosis		
	Diverticulitis		Pancreatitis		
	Dyspnea on exertion		PCOS		
	Gallstones		Pseudotumor cerebri		
	GERD		Pulmonary embolus		
	GI Ulcers		Pulmonary hypertension		

Surgical History: Have you had any of the following surgeries?

	Abdominal surgery: type: Open or laproscopic		Hernia repair: location: With mesh: yes or no		Vertical banded gastroplasty/horizontal gastroplasty
	Appendectomy		Intestinal bypass		Vertical sleeve gastrectomy
	Biliopancreatic Diversion (BPD)		Lap Band or Realize Band		
	BPD with duodenal switch		Liver transplant		
	CABG (cardiac bypass)		Nissen fundoplication		
	Cholecystectomy		Roux-en-Y (gastric bypass)		
	Colectomy		Vagotomy		

I have not had any surgery: ____

Pre-operative risk screening: do you have or do you use any of the following?

	Abnormal ECG		Routine use of steroids		
	Alcoholism		Use of hormones		
	Addiction (other)		Use of nicotine		
	Cannot receive blood products				
	Hgb A1C >8.0				
	Routine use of Aspirin				
	Routine use of NSAIDs				

Diagnostic Procedures:

Test	Date	Where was test done	Why was test done
Last blood work			
Upper GI			
Upper Endoscopy			
Lower GI			
Colonoscopy			
Abdominal ultrasound			
EKG or Stress test			
Echo-cardiogram			
Heart catheterization			
Sleep study			
Pulmonary function test			
Chest x-ray			
CT scan			
MRI			

Family History

Relationship	No problem	Arthritis	Asthma	Cancer (type)	COPD	Depression	Heart disease	High Lipids	High BP	Kidney disease	Mental illness	Stroke	Clotting disorder	Obesity	Hemophilia	Anemia			
Mother																			
Father																			
Brother																			
Sister																			
MGM																			
MGF																			
PGM																			
PGF																			
Other																			
Other																			

Psychosocial History

Any Alcohol Use:
☐Yes ☐No
If yes, describe frequency and amount?

Any History of Drug Abuse
☐Yes ☐No
If yes, describe frequency and amount?

Any <u>current</u> Tobacco Use
☐Yes ☐No

<u>If yes what form of tobacco?</u>

☐Cigs ☐Cigars ☐Dip ☐Chew ☐E-cigs
Other _____

<u>How often?</u>
☐>2 packs per day
☐1-2 packs per day
☐<1 pack per day
☐Dip or Chew or Other _____

<u>Any **past** use of tobacco/nicotine?</u>
☐Yes ☐No

Starting age? _____

What year did you quit? _____

Any Difficulty with Daily Tasks:

Can you:

●Can take care of self, such as eat, dress, or use the toilet (1 MET)
Yes No

●Can walk up a flight of steps or a hill or walk on level ground at 3 to 4 mph (4 METs)
Yes No

●Can do heavy work around the house such as scrubbing floors or lifting or moving heavy furniture or climb two flights of stairs (between 4 and 10 METs)
Yes No

●Can participate in strenuous sports such as swimming, singles tennis, football, basketball, and skiing (>10 METs)
Yes No

Religious beliefs:

May you receive blood or blood products?
☐Yes ☐No

Other: _____
_____
_____

Support System:
Who is your support system for your weight loss? _____
_____
_____
_____

History of Weight Gain

What is your: Lowest adult weight? _____ Highest adult weight? _____

How long have you been overweight? __ Childhood __ adolescence __ adulthood __ after pregnancy

Contributing Factors?

___ Frequent snacking	___ Genetics/Family	___ Illness	___ Insomnia/Poor Sleep
___ Lack of exercise	___ Poor food choices	___ Large portions	___ Nighttime eating
Medications	Family Stressors		

Weight Loss Medications

Please indicate which medications you have used to lose weight.	Dates Or Number of months on medication: Any problems from taking the medication:	Pounds lost (est.)
Fen-phen		
HCG		
Alli or Xenical (orlistat)		
Meridian (sibutramine)		
Byetta		
Victoza/Saxenda		
Adipex (phentermine)		
Belviq (locaserin)		
Qsymia (phentermine/topiramate)		
Bupropion		
Contrave (naltrexone/bupropion)		
Other over the counter:		

Weight Loss Attempt History

Please indicate which diets you have tried in the past:	Dates	Pounds lost
Atkins diet / South Beach (or other low-carb diet)		
Jenny Craig / Nutrisystem		
Weight Watchers		
Optifast / Medifast / Slimfast		
LA Weight Loss		
Calorie counting (on my own)		
Other		
Most lost in any one attempt?		

Weight Loss Surgery History: (fill this out ONLY if you have had surgery for weight loss in the past)

Have you previously had weight loss surgery? ☐Yes ☐No (if no skip this section)
What year?
Name of Surgeon: Last seen: if applicable, last band adjustment:
Weight before bariatric surgery: lbs
Lowest weight achieved after bariatric surgery: lbs
Did you have any adverse events occur during or after the previous bariatric surgery? ☐Yes ☐No if "yes" please explain:

Sleep Questionnaires

STOP-BANG Sleep Apnea Questionnaire

STOP (completed by patient)

Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?
Yes No

Do you often feel TIRED, fatigued, or sleepy during daytime?
Yes No

Has anyone OBSERVED you stop breathing during your sleep?
Yes No

Do you have or are you being treated for high blood pressure**?**
Yes No

BANG (completed by office)

BMI more than 35kg/m2? **Yes No**
AGE over 50 years old? **Yes No**
NECK circumference > 16 inches (40cm)? **Yes No**
GENDER: Male? **Yes No**

TOTAL SCORE
High risk of OSA: Yes 5 - 8
Intermediate risk of OSA: Yes 3 - 4
Low risk of OSA: Yes 0 - 2

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?
This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:
0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Chance of Dozing Answer 0-3

Situation	Chance of Dozing
1. Sitting, inactive in a public place (e.g., theater or a meeting	□0 □1 □2 □3
2. Watching TV	□0 □1 □2 □3
3. Sitting and Reading	□0 □1 □2 □3
4. Sitting and talking to someone	□0 □1 □2 □3
5. Sitting quietly after lunch without alcohol	□0 □1 □2 □3
6. As a passenger in a car for an hour without a break	□0 □1 □2 □3
7. Lying down to rest in the afternoon when circumstances permit	□0 □1 □2 □3
8. In a car, while stopped for a few minutes in the traffic	□0 □1 □2 □3

1 – 6: Congratulations, you are getting enough sleep!
7 – 8: Your score is average
9 - >: Seek the advice of a sleep specialist without delay

Final Thoughts:

Please provide any comments or questions here that you would like:

Name: _____ **Date of Birth:** _____

Review of Symptoms: Do you *currently* have you any of the following:

	Constitution		Eyes		Respiratory		Skin
	Fevers		Blurred vision		Cough		Discoloration of skin
	Generalized weakness		Eye pain		Hemoptysis (coughing up blood)		Dryness
	Malaise/fatigue				Shortness of breath (anytime)		Itching
	Night sweats				Sleep disturbances due to breathing		Poor wound healing
	Headaches				Snoring		Rash
					Sputum production		Skin cancer
					Wheezing		Unusual hair distribution
					Cough		
					Hemoptysis (coughing up blood)		
					Shortness of breath (anytime)		
					Sleep disturbances due to breathing		
					Snoring		
					Sputum production		
					Wheezing		
	HENT		**Cardiovascular**		**Endocrine**		**Musculoskeletal**
	Headaches		Chest pain		Intolerance of cold		Joint pain
	Hearing loss		Leg pain when walking (Claudication)		Intolerance of heat		Back pain
	Hoarseness		Cyanosis (turning blue)		Polydipsia (increased thirst)		Falls
	Jaundice (eyes are yellow)		Dyspnea on exertion (short of breath with activity)		Polyphagia (increased hunger)		
	Nosebleeds		Irregular heart beats		Polyuria (increased urination)		
			Leg swelling				
			Near-syncope (passing out)		**Heme/Lymph**		
			Orthopnea (short of breath lying down)		Easy bruising/bleeding		
			Palpitations (heart flutter)				
			PND (shortness of breath that wakes you)				
			Syncope (passing out)				

Name: _____ **Date of Birth:** _____

Review of Symptoms: Do you *currently* have you any of the following:

	Gastrointestinal		Genitourinary		Neurological		Psychiatric
	Abdominal bloating		Flank pain (side pain)		Concentration difficulty		Depression
	Abdominal pain		Urinary frequency		Coordination disturbances		Memory loss
	Anorexia (loss of appetite)		Hematuria (blood in urine)		Dizziness (sense of being off balance)		Nervous/anxious
	Bowel habits change		Hesitancy (difficulty to start urination)		Light-headedness		Substance abuse
	Bowel incontinence (leakage)		Dysuria (painful urination)		Loss of balance		
	Constipation		Incomplete emptying of bladder		Numbness		**Aller/Immuno**
	Diarrhea		Menorrhagia (heavy periods)		Paresthesia (abnormal sensation of skin)		Environmental allergies
	Dysphagia (difficulty swallowing)		Missed menses (periods)		Sensory change		Hives
	Flatus (gas)		Nocturia (urination at night)		Tremors (shaking of one or more body part)		Persistent infections
	Heartburn		Non-menstrual bleeding		Vertigo (sensation of spinning or swaying)		
	Hematemesis (vomiting blood)		Pelvic pain				
	Hematochezia (bright red rectal bleeding)						
	Jaundice (yellow skin)						
	Melena (dark red rectal bleeding)						
	Nausea						
	Vomiting						