Stanford HEALTH CARE
STANFORD MEDICINE

ValleyCare

Outpatient Nutrition Registration Form

Name: ____________________ Social Security# ____________

Gender: ____________ DOB: ____________

Address: ____________________ City: ____________ Zip: ____________

Home phone: ____________ OK to leave message? ☐ Yes ☐ No

Cell/work: ____________ OK to leave message? ☐ Yes ☐ No

Email address (please print clearly): ____________________

Marital Status ☐ S ☐ M ☐ D ☐ W ☐ P

Drivers License # ____________ Race: ____________ Religion: ____________

Occupation: ____________ Employer: ____________

Employer Address: ____________________

Emergency Contact: ____________ Relationship: ____________ Phone Number: ____________

Primary Care Physician: ____________________

Would you like to sign up for "My Health"? It is a patient portal to access medical records and email your providers. ☐ Yes ☐ No

May we keep you informed of program updates, special speakers and events via our email newsletter (sent monthly) ☐ Yes ☐ No

Insurance Information:

Primary Insurance Co. ____________ ID# ____________ Group # ____________

Subscriber Name: ____________ DOB: ____________ Subscriber Phone ____________

Subscriber Address: ____________________ City: ____________ Zip: ____________

Secondary Insurance Co. ____________ ID# ____________ Group # ____________

Subscriber Name: ____________ DOB: ____________ Subscriber Phone ____________

Subscriber Address: ____________________ City: ____________ Zip: ____________

Patient Signature: ____________________ Date: ____________

☐ Electronic signature

Name: ______________________ Date: ______________

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DOB: ______________ Gender ______________

Age: _____

Weight Loss Center
Patient History & Lifestyle Questionnaire

Please answer each question to the best of your ability. Then mail/mail/fax a completed copy to the Weight Loss Center prior to your appointment (5725 W. Las Positas Blvd Suite 220 Pleasanton, CA 94588 or fax 925-416-6722). It is very important that we have adequate information to prepare for your visit, so **if we do not receive your questionnaire in advance, your appointment may need to be rescheduled.**

Primary Care Physician: ______________________ PCP Address: ______________________

PCP Phone Number: ______________________ PCP Fax: ______________________

Reason for Consultation: ______________________

WEIGHT HISTORY

Height: ________ Current Wt (lbs): ________ Approximate wt 5 years ago: ________ 1 year ago: ________

When did you become overweight/obese? ______________________

Lowest adult weight (lbs)? ________ Highest adult weight (lbs)? ________ Desired goal weight (lbs)? ________

Are there any specific triggers that have caused you to gain weight?

☐ Pregnancy ☐ Medication ☐ Stopped smoking ☐ Job change ☐ Divorce ☐ Emotional Issues
☐ Moving ☐ Injury or activity change Other: ______________________

WEIGHT LOSS PROGRAMS/DIETS/MEDICATIONS

Method of Weight Loss	YES	NO	When?	Duration (How long?)	Max Weight Loss
Weight Watchers, Jenny Craig, Nutrisystem	☐	☐			
Low carb diet	☐	☐			
Self-managed diet modification	☐	☐			
Exercise	☐	☐			
Weight Loss Surgery	☐	☐			
Diet program supervised by doctor, dietitian or hospital	☐	☐			
Over the coiunter diet pills	☐	☐			
Rx Wt Loss Med ______	☐	☐			
Liquid fast/Optifast/Medifast	☐	☐			
Other: ______	☐	☐			

MEDICAL HISTORY

Have you had any of the following obesity-related problems?

Diabetes Mellitus	☐ Yes	☐ No
Heartburn/GERD	☐ Yes	☐ No
Other stomach/Intestinal Problems	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Joint pain/Arthritis	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No
Using CPAP or BiPAP?	☐ Yes	☐ No
Is it working?	☐ Yes	☐ No
Depression/Anxiety/Bipolar disorder	☐ Yes	☐ No

Other ____________________

SURGERIES and HOSPITALIZATIONS

DATE	Procedure/Surgery or Reason for hospitalization	Hospital

ANESTHESIA

Please list any problems/complications you have had with anesthesia: ____________________

____

____

MEDICATIONS

Medication Allergies? ________

If yes, please list allergies with reaction: ____________________

OTHER ALLERGIES:

Surgical Tape? ________ Latex? ________ Iodine? ________

Name: ______________________ Date: ____________

DOB: ____________

PRESCRIPTION MEDICATIONS

(Add below or attach typed list. Please include over the counter medications.)

☐ **NO MEDICATIONS**

Medication	Strength	How you take it	Reason
EXAMPLE: Atenolol	*50mg*	*Once Daily*	*High blood pressure*

Vitamins/Herbal/Nutritional Supplements

Name	Strength	How you take it	Reason

Name ______________________________

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FAMILY MEDICAL HISTORY

Please indicate which, if any, of your family members have or had the following:

	Sibling	Mother	Father	Grandparent	Aunt/Uncle
Anemia	☐	☐	☐	☐	☐
Bleeding problems	☐	☐	☐	☐	☐
Blood clots	☐	☐	☐	☐	☐
Cancer (breast)	☐	☐	☐	☐	☐
Cancer (colon)	☐	☐	☐	☐	☐
Cancer (other)	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Gallstones	☐	☐	☐	☐	☐
Gout	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐

Is your father living? __________ If not, cause/age of death: ______________________________

Is your mother living? __________ If not, cause/age of death: ______________________________

Are any family members obese? Please list obese relatives (i.e. father, aunt) and approximate weights.

MEDICAL HISTORY

Have you recently had any of the following?

Physical Exam ☐ Yes ☐ No If yes, date: ______________

Where/Doctor's Name ______________________ Doctor's Phone Number ______________

Blood Test ☐ Yes ☐ No If yes, date: ______________

Where/Doctor's Name: ______________________ Doctor's Phone Number: ______________

Have you EVER had any of the following?

EKG ☐ Yes ☐ No If yes, date: ______________

Where/Doctor's Name: ______________________ Doctor's Phone Number: ______________

Echocardiogram ☐ Yes ☐ No If yes, date: ______________

Where/Doctor's Name: ______________________ Doctor's Phone Number: ______________

☐ Yes ☐ No

Cardiac Stress Test If yes, date: __________

Where/Doctor's Name: __________ Doctor's Phone Number: __________

Angiogram ☐ Yes ☐ No If yes, date: __________

Where/Doctor's Name: __________ Doctor's Phone Number: __________

Upper Endoscopy ☐ Yes ☐ No If yes, date: __________

Where/Doctor's Name: __________ Doctor's Phone Numbe:r __________

Colonoscopy ☐ Yes ☐ No If yes, date: __________

Where/Doctor's Name: __________ Doctor's Phone Number: __________

Sleep Study ☐ Yes ☐ No If yes, date: __________

Where/Doctor's Name: __________ Doctor's Phone Number: __________

Diabetes Education ☐ Yes ☐ No If yes, when and how many visits? __________

Where/Ordering Doctor? __________ Doctor's Phone Number: __________

Personal Medical History/Review of Systems: Please check all that apply.

CONSTITUTIONAL

Good general health	☐ Never	☐ Past	☐ Present
Unexplained weight change	☐ Never	☐ Past	☐ Present
Fever	☐ Never	☐ Past	☐ Present
Fatigue	☐ Never	☐ Past	☐ Present
Headaches	☐ Never	☐ Past	☐ Present

EYES

Disease or injury	☐ Never	☐ Past	☐ Present
Glasses/contacts	☐ Never	☐ Past	☐ Present
Blurred/double vision	☐ Never	☐ Past	☐ Present
Recent change in vision	☐ Never	☐ Past	☐ Present

EARS/NOSE/MOUTH/THROAT

Hearing loss/ringing	☐ Never	☐ Past	☐ Present
Earaches or drainage	☐ Never	☐ Past	☐ Present
Chronic sinus problems	☐ Never	☐ Past	☐ Present
Chronic runny nose	☐ Never	☐ Past	☐ Present
Nose bleeds	☐ Never	☐ Past	☐ Present

EARS/NOSE/MOUTH/THROAT (CONT)

Mouth sores	☐ Never	☐ Past	☐ Present
Bleeding gums	☐ Never	☐ Past	☐ Present
Bad breath or bad taste	☐ Never	☐ Past	☐ Present
Sore throat or voice change	☐ Never	☐ Past	☐ Present
Swollen glands in neck	☐ Never	☐ Past	☐ Present

RESPIRATORY

Chronic or frequent cough	☐ Never	☐ Past	☐ Present
Coughing/choking at night	☐ Never	☐ Past	☐ Present
Spitting up blood	☐ Never	☐ Past	☐ Present
Shortness of breath	☐ Never	☐ Past	☐ Present
Asthma or wheezing	☐ Never	☐ Past	☐ Present
Daytime sleepiness	☐ Never	☐ Past	☐ Present
Lung disease	☐ Never	☐ Past	☐ Present
Tuberculosis	☐ Never	☐ Past	☐ Present

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CARDIOVASCULAR

Heart trouble	☐ Never	☐ Past	☐ Present
Chest pain or angina pectoris	☐ Never	☐ Past	☐ Present
Heart murmurs	☐ Never	☐ Past	☐ Present
Blood clot	☐ Never	☐ Past	☐ Present
Palpitations/racing heart	☐ Never	☐ Past	☐ Present
Shortness of breath with walking or lying flat	☐ Never	☐ Past	☐ Present
Swelling of feet, ankles, or hands	☐ Never	☐ Past	☐ Present

GASTROINTESTINAL

Colitis: Irritable Bowel Syndrome	☐ Never	☐ Past	☐ Present
Crohn's Disease or Ulcerative Colitis	☐ Never	☐ Past	☐ Present
Gallbladder Disease/ Gallstones	☐ Never	☐ Past	☐ Present
Change in bowel movements	☐ Never	☐ Past	☐ Present
Painful bowel movements	☐ Never	☐ Past	☐ Present
Constipation	☐ Never	☐ Past	☐ Present
Frequent diarrhea	☐ Never	☐ Past	☐ Present
Rectal bleeding	☐ Never	☐ Past	☐ Present
Blood in or tarry stools	☐ Never	☐ Past	☐ Present
Nausea/Vomiting	☐ Never	☐ Past	☐ Present
Loss of appetite	☐ Never	☐ Past	☐ Present
Heartburn or GERD	☐ Never	☐ Past	☐ Present
Peptic ulcer (stomach/duodenal)	☐ Never	☐ Past	☐ Present
Hiatal hernia	☐ Never	☐ Past	☐ Present
Abdominal pain	☐ Never	☐ Past	☐ Present
Hepatitis: liver disease	☐ Never	☐ Past	☐ Present

GENITOURINARY

Frequent urination	☐ Never	☐ Past	☐ Present
Burning or painful urination	☐ Never	☐ Past	☐ Present
Leakage of urine or dribbling	☐ Never	☐ Past	☐ Present
Change in force of stream urinating	☐ Never	☐ Past	☐ Present
Blood in urine	☐ Never	☐ Past	☐ Present

GENITOURINARY (CONT)

Kidney Infection	☐ Never	☐ Past	☐ Present
Kidney stones	☐ Never	☐ Past	☐ Present
Sexual difficulty	☐ Never	☐ Past	☐ Present
Hernia	☐ Never	☐ Past	☐ Present
Testicular pain	☐ Never	☐ Past	☐ Present

FEMALES ONLY:

Pain with periods	☐ Never	☐ Past	☐ Present
Vaginal discharge	☐ Never	☐ Past	☐ Present
Irregular periods	☐ Never	☐ Past	☐ Present

Form of birth control if any: ______________________________

Taking hormone replacement? ☐

Number of pregnancies: ________ Live births: ________

Date of last menstrual period: ____________

Date of last pap smear/pelvic exam: ____________

Date of last mammogram: ____________

Ordering physician: ______________________________

Physician Phone Number: ____________________

Physician address: ______________________________

MUSCULOSKELETAL

Joint pain	☐ Never	☐ Past	☐ Present
Joint stiffness or swelling	☐ Never	☐ Past	☐ Present
Arthritis	☐ Never	☐ Past	☐ Present
Gout	☐ Never	☐ Past	☐ Present
Weakness of muscles or joints	☐ Never	☐ Past	☐ Present
Muscle pain or cramps	☐ Never	☐ Past	☐ Present
Back pain	☐ Never	☐ Past	☐ Present
Difficulty walking	☐ Never	☐ Past	☐ Present
Cold extremities	☐ Never	☐ Past	☐ Present

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INTEGUMENTARY (skin, breast)

Rash or itching	☐ Never	☐ Past	☐ Present
Change in skin color	☐ Never	☐ Past	☐ Present
Change in hair or nails	☐ Never	☐ Past	☐ Present
Suspicious moles or spots	☐ Never	☐ Past	☐ Present
Varicose veins	☐ Never	☐ Past	☐ Present
Breast pain	☐ Never	☐ Past	☐ Present
Breast lump	☐ Never	☐ Past	☐ Present
Breast discharge	☐ Never	☐ Past	☐ Present

NEUROLOGICAL

Frequent/recurring headache	☐ Never	☐ Past	☐ Present
Lightheaded or dizzy	☐ Never	☐ Past	☐ Present
Seizures	☐ Never	☐ Past	☐ Present
Numb or tingling sensations	☐ Never	☐ Past	☐ Present
Tremors	☐ Never	☐ Past	☐ Present
Stroke	☐ Never	☐ Past	☐ Present
Paralysis	☐ Never	☐ Past	☐ Present
Head injury	☐ Never	☐ Past	☐ Present

ENDOCRINE

Glandular or hormonal problem	☐ Never	☐ Past	☐ Present
Excessive thirst or urination	☐ Never	☐ Past	☐ Present
Heat or cold intolerance	☐ Never	☐ Past	☐ Present
Dry skin	☐ Never	☐ Past	☐ Present

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts	☐ Never	☐ Past	☐ Present
Anemia	☐ Never	☐ Past	☐ Present

HEMATOLOGIC/LYMPHATIC (CONT)

Bleeding or bruising tendency	☐ Never	☐ Past	☐ Present
Phlebitis	☐ Never	☐ Past	☐ Present
Past blood transfusion	☐ Never	☐ Past	☐ Present
Enlarged glands	☐ Never	☐ Past	☐ Present

ALLERGIC/IMMUNOLOGIC

Lupus/Autoimmune disorder	☐ Never	☐ Past	☐ Present

Food Allergy to: ______________________

Skin reaction or other negative reaction to:

Penicillin or other antibiotics	☐ Never	☐ Past	☐ Present
Morphine, Demerol, other narcotics	☐ Never	☐ Past	☐ Present
Novocaine or other anesthetics	☐ Never	☐ Past	☐ Present
Aspirin or other pain remedies	☐ Never	☐ Past	☐ Present
Tetanus antitoxins or other serums	☐ Never	☐ Past	☐ Present
Iodine, methiolate, other antiseptic	☐ Never	☐ Past	☐ Present
Other drugs/ medications	☐ Never	☐ Past	☐ Present

PSYCHIATRIC

Memory loss or confusion	☐ Never	☐ Past	☐ Present
Anxiety/Nervous/ Panic Attacks	☐ Never	☐ Past	☐ Present
Depression	☐ Never	☐ Past	☐ Present
Bipolar disorder	☐ Never	☐ Past	☐ Present
Insomnia	☐ Never	☐ Past	☐ Present

Other: ______________________

GENERAL/SOCIAL HISTORY

Marital Status: ______________ Partner: ______________

Highest Level of Education: ______________

Occupation: ______________ Hours/week you work? ______

With whom do you reside? ______________ Number of Children: ______ Ages of children: ______________

List activities, hobbies, personal interests, etc. ______________________

Name: ______________________

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LIFESTYLE CHOICES/HABITS

Average number hours you sleep/night: ______ Is this enough for you? ______

Do you smoke now? ______ If yes, how many packs/day: ______

Have you ever smoked? ______ If yes, age started: ______ Age quit: ______

Have you ever used any recreational/illegal drugs (i.e. marijuana)? ______

Currently? ______ Explain: ______________________

Approximately how much of each of the following beverages do you consume?

Beer	______	12 oz cans/wk	Tea w/caffeine	______	cups/day	Water	______	cups/day
Wine	______	4 oz glasses/wk	Coffee w/caffeine	______	cups/day	Regular Soda	______	cans/day
Liquor	______	2 oz. drinks/wk	Milk	______	cups/day	Diet Soda	______	cans/day
Juice	______	cups/day						

Other beverage choices: ______________________

DIET AND EXERCISE HABITS

With whom do you typically eat? ☐ Alone ☐ Family Other (explain): ______________________

Who typically does the food shopping for your household? ______________________

Who usually prepares the food you eat at home? ______________________

Are you confident that you can effectively read food labels to select nutritious food? ☐ Yes ☐ No

Please list any food allergies or intolerances: ______________________

Have you ever been a binge eater? ☐ Yes ☐ No Do you sometimes binge now? ☐ Yes ☐ No Frequency: ______

Have you ever purged (vomited on purpose) after eating too much? ☐ Yes ☐ No

Do you do this now? ☐ Yes ☐ No Explain: ______________________

Do you ever get up after going to bed to have something to eat? ☐ Yes ☐ No

Are you a more: ☐ Structured eater ☐ haphazard eater Explain: ______________________

What eating habits do you have that bother you or contribute to your weight problem?

Briefly describe a "typical" day's food intake:

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Snacks: ______________________

Please select the best answer for each question about your typical food habits:

3. How often do you eat three meals in a day (breakfast, lunch and dinner)?

☐ Always ☐ Some days ☐ Most days ☐ Rarely/Never

4. Which meal is most often skipped?

☐ Breakfast ☐ Lunch ☐ Dinner ☐ No skipped meals usually

Why? ______________________________

3. How often do you "snack" (defined as any food eaten between meals or after dinner)?

☐ Rarely or never ☐ once/day ☐ 2-3 times/day ☐ Often graze on food throughout the day

4. How often do you crave sweets (candy, cookies, donuts, pastries, etc.)?

☐ < 3 times/week ☐ 3-5 times/week ☐ once/day ☐ 2 or more times/day

5. How frequently do you eat until very full or uncomfortable?

☐ most meals ☐ often ☐ occasionally ☐ Rarely/Never

What is most likely to prompt you to overeat? ______________________________

6. How often do you typically eat in restaurants? Count breakfasts, lunches, & dinners (do not include fast food/take out food):

☐ 1 meal/week or less ☐ 2 meals/week ☐ 3-4 meals/week ☐ 5 meals/week or more

7. How often do you eat fast food, cafeteria, or take-out meals? Count all breakfasts, lunches and dinners:

☐ 1 meal/week or less ☐ 2 meals/week ☐ 3-4 meals/week ☐ 5 meals/week or more

8. What is your usual fruit and vegetable intake (combined)?

☐ < 1 serving/day ☐ 1-2 servings/day ☐ 3-4 servings/day ☐ 5 or more servings/day

9. Which protein foods do you typically eat? (check all that apply)

☐ Chicken ☐ Fish/shellfish ☐ Cheese/cottage cheese

☐ Meat/beef ☐ Eggs ☐ Soy/tofu

10. How long does it usually take you to eat a meal?

☐ 1-10 minutes ☐ 10-20 minutes ☐ 20-30 minutes ☐ At least 30 minutes

11. Which emotions will cause you to eat larger portions, more snacks or choose different foods? (Check all that apply)

☐ Stress ☐ Loneliness ☐ Sadness/depression

☐ Anger ☐ Boredom ☐ Happiness/celebrating

Other: ______________________________

EXERCISE

Are you a regular exerciser currently? (Includes regular walking) __________

If yes, what type(s) of exercise do you typically do? ______________________________

How many days/week do you exercise? __________ How long each time? __________

Any physical restrictions that keep you from exercising? __________

Explain: ______________________________

Name: ______________________________

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The following information is extremely important and very confidential. Honesty is needed in order to provide you with the best possible treatment plan.

Do you have a history of abuse? (Please include emotional, physical, mental, substance, or other types of abuse you've dealt with.) ☐ Yes ☐ No ☐ Unsure

If YES, when? ______________ Explain: ______________________________

Have you ever sought treatment for depression, anxiety, panic attacks, bipolar disorder or another mental health problem? ☐ Yes ☐ No ☐ Unsure

If YES, when? ______________ Explain: ______________________________

Have you ever been in treatment wiht a psychologist (therapist)? ☐ Yes ☐ No ☐ Unsure

☐ Group ☐ Individual When and for how long? ______________________________

If YES, please provide therapist's name: ______________ Therapist Phone Number: ______________

Have you ever been in treatment wiht a psychiatrist? ☐ Yes ☐ No Are you currently receivint treatment? ☐ Yes ☐ No

If YES, please provide therapist's name: ______________ Therapist Phone Number: ______________

Are you currently taking any psychiatric medications (antidepressant, med for anxiety, etc)? ☐ Yes ☐ No

If YES, please list medications on page 4 AND provide name and phone of prescribing doctor:

Prescriber name: ______________ Phone Number: ______________

Have you ever been hospitalized for mental health reasons? ☐ Yes ☐ No

Explain: ______________________________

Have you ever been treated for alcohol abuse or chemical dependency? ☐ Yes ☐ No

Explain: ______________________________

Have you ever attended AA or NA meetings? ☐ Yes ☐ No Are you attending now? ☐ Yes ☐ No

Explain: ______________________________

Describe your present life stressors: ______________________________

Describe your present support system you rely upon (church, spouse, family, friends, co-workers, etc.): ______________________________

Have you ever intentionally injured yourself? ☐ Yes ☐ No

If so, when and how? ______________________________

Have you ever tried to kill yourself? ☐ Yes ☐ No

If so, when and how? ______________________________

Have you ever intentionally injured someone else? ☐ Yes ☐ No

If so, when and how? ______________________________

OTHER PHYSICIANS (Primary Care doctor should already be listed on page 2

Gynecologist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number: ____________

Orthopedist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number:: ____________

Endocrinologist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number:: ____________

Psychiatrist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number: ____________

Psychotherapist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number: ____________

Cardiologist Name: ____________ Address: ____________

Phone Number: ____________ Fax Number: ____________

Other MD Name/
specialty: ____________ Address: ____________

Phone Number: ____________ Fax Number: ____________

Patient Signature: ____________________________

☐ Electronic signature

Referral Source

How did you hear about us?

☐ Internet

☐ Insurance/Hospital Referral

☐ Patient referral ____________

☐ Physician referral ____________

☐ Other ____________