LUCKAY DOC PLLC

New Patient Information

NAME_____DATE_____

Please tell us what you would like help with

Hormones_____Weight_____

1. PAST MEDICAL HISTORY

Have you been diagnosed with any medical problems? If so please list them

_____

_____

_____

_____

Have you ever been treated by a healthcare provider for anxiety, depression, or other mental health issues? Yes____ No___

Allergic to any medication or food?_____

2. Past Surgical History

_____

_____

_____

3.Current Medications	Current Supplements/Vitamins
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Current hormone replacement therapy? If so, what?_____

Past hormone replacement therapy? If so, what?_____

4.Sleep History

Do you have difficulty falling asleep ? Yes__ No___Staying asleep? Yes___No__

How long do you sleep?____hours/night Do you wake up tired? Yes__No__

Do you snore? Yes__ No__ Do you have sleep apnea? Yes___ No___

5. Weight History

If you are not concerned about your weight please skip this section

When did you first begin to gain weight? As a child? _____; a teen? _____; a young adult? _____; at mid-life? _____. Please explain if none of these fit you_____

_____

Was the weight gain rapid? _____or slow? _____

Were other factors involved with the weight change such as stress?____; marriage?_____;divorce?____;illness?____;medication?____;abuse?____; travel?____;trauma?____other?_____

What have you tried in the past to lose weight? a commercial program? ____; self-directed "popular" diet? _____; support group? ____; physician directed program? _____

What worked best for you? _____

What about it did you like and dislike? _____

What hasn't worked? _____

Why not? _____

Have you used any diet medications? _____When? _____What was it? _____Any problems with it? _____How did it work for you? _____

Have you ever been diagnosed with and treated by a healthcare professional for an eating disorder such as bulimia; Binge Eating Disorder; Anorexia nervosa; or Night eating Syndrome? Yes___ No___

6. SOCIAL HISTORY

Are you employed?_____. If yes, where?_____

At work do you move around or sit most of the time?_____

Do you live alone or with someone?_____

Do you typically eat alone?_____

Do you smoke/chew/dip?_____How much?_____Since how old?_____

Do you drink alcohol?_____How often?_____How much?_____

Please tell us about any major life stresses_____

_____

Have you been in an abusive relationship? Yes____ No_____ If yes please explain_____

_____

7.EXERCISE HISTORY

What is your current physical activity level? Sedentary? _____, moderate? _____; active? _____

Identify a favorite activity you used to do in the past? _____

Are there any barriers to physical activity? _____

How do you spend your day? Chasing children?_____desk work?_____Active work?_____

8. DIETARY HISTORY

Do you eat at defined times?_____Or graze throughout the day?_____

What times of day do you eat?_____

What are your eating triggers? People?___ places?___; activites?___; feeling such as stress, boredom, anger? Do you cook your meals?____or eat out?_____

Are there any foods you can't do without?_____

Do you drink soda/soft drinks?_____How many per day?____Diet or regular? Do you drink tea?_____Sweet or unsweet? Do you use artificial sweetners?_____ Do you drink coffee?_____ How much per day?_____

FOR WOMEN ONLY

When did you first begin menstruating?_____ Any problems?_____ Have you ever been pregnant?_____

Any problems?_____

When was your last period?_____ Date of last Pap Smear?_____

History/Treatments for abnormal Pap? Yes__ No__

Do you have acne? Yes__ No__ PCOS? Yes__ No__

Fibrocystic breasts Yes__ No__ Uterine fibroids? Yes __ No__

Facial hair? Yes__ No__ Hair loss? Yes__ No__

What is your current birth control method?_____

FOR MEN ONLY

Do you get up at night to urinate? Yes__ No__ Do you have difficulty starting a urine stream? Yes__ No__ When was your last prostate check?_____