NY|WC
NEW YOU WELLNESS CENTER

Patient Registration Form

Name (Last, First, M.I.) _____ **Male or Female** **DOB:** _____

Age: _____ **Email Address:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone Number: _____ **Cell Phone Number:** _____

Driver's License Number: _____ **Social Security Number:** _____

May we send you a text message reminder the day before your appointment? _____

How did you hear about New You Wellness Center?

☐ Billboard ☐ Coupon ☐ Direct Mailing ☐ Employee ☐ Internet
☐ Newspaper ☐ Patient/Friend ☐ Radio ☐ Walk-in ☐ Magazine

Which Dr. / Friend, if any referred you ?

Goal Weight: _____ **When was the last time (if ever) you were at the weight?**

Patient Health History

Have you had a Comprehensive Physical Exam within the last 12 months?	☐ Yes	☐ No
Have you had an EKG in the last 12 months?	☐ Yes	☐ No
If Yes, was it normal?	☐ Yes	☐ No

Women Only:

Date of last menstruation? _____

Are you on birth control? _____

Last Well Women Exam: _____

Last mammogram: _____

Are you pregnant, trying for pregnancy or currently breastfeeding? ☐ Yes ☐ No

Allergies to Medications

Medication Name	Reaction

Prescribed Medications and OTC drugs, Dietary Supplements (including vitamins, inhalers, etc.)

Medication Name	Strength	Frequency

History of Cardiac Disorder / Event ☐ NONE

☐ Myocardial infarction Date: _____
☐ Cerebrovascular accident Date: _____
☐ Thrombosis / Embolism Date: _____

- [ ] Coronary artery bypass graft surgery / CABG — Date: _____
- [ ] Aortic Valve Disorder — Date: _____
- [ ] Mitral Valve Disorder — Date: _____
- [ ] Endocarditis — Date: _____
- [ ] Pericarditis — Date: _____
- [ ] Cardiomyopathy — Date: _____
- [ ] Cardiac conduction disorder (AV block, Bundle Branch block, Mobitz type II AV) — Date: _____
- [ ] Cardiac Arrhythmia (Atrial fibrillation/flutter, Paroxysmal supraventricular tachyc — Date: _____
- [ ] Heart failure (congestive heart failure, etc.) — Date: _____

Past Medical History — [ ] **NONE**

- [ ] Prior Hormone Replacement Therapy
- [ ] Sleep Apnea: _____
- [ ] Snoring
- [ ] Chronic Kidney Disease
- [ ] Abnormal Liver function
- [ ] Heart Disease: _____
- [ ] High Blood Pressure: _____
- [ ] High Cholesterol _____
- [ ] Peripheral Artery Disease
- [ ] Chronic Lymph Node Enlargement
- [ ] Inability to have children
- [ ] COPD
- [ ] Insomnia
- [ ] Diabetes I
- [ ] Diabetes II
- [ ] Hypothyroidism
- [ ] Enlarged Thyroid
- [ ] Enlarged Prostate
- [ ] Hx of Prostate Cancer
- [ ] Hypogonadism
- [ ] Depression
- [ ] Anxiety
- [ ] HIV
- [ ] Mumps
- [ ] Acid Reflux
- [ ] Gout
- [ ] Headaches (frequent)
- [ ] Anemia
- [ ] Hemochromatosis
- [ ] Bleeding disorder:
- [ ] Obesity
- [ ] Cottonseed Allergy
- [ ] History of Seizures
- [ ] Cancer:
- [ ] Cardiovascular Disease
  - [ ] Blood Clot
  - [ ] Chest pain
  - [ ] Heart Attack
  - [ ] Heart Failure
  - [ ] Stroke
- [ ] Other:

For Women Only

- [ ] Endometriosis
- [ ] Fibroids
- [ ] Polycystic Ovarian Disease (PCOS)

Past Medical History — [ ] **NONE**

- [ ] Family history of prostate cancer
- [ ] First degree relative _____
- [ ] Family history of cardiovascular disease
  - Heart Attack [ ] Stroke [ ]
- [ ] Family history of endocrine disease
  - [ ] Diabetes [ ] Hypothyroidism [ ] Reproductive Disorder [ ] Delayed Puberty
- [ ] Family history of breast cancer
- [ ] Family history of ovarian cancer
- [ ] Other

Social History

EXERCISE

How often are you physically active for 20 minutes or longer

- [ ] Never [ ] 1-2 x/week [ ] 3-4 x/week [ ] 5+ x/week

Which type(s) of exercise do you do? (check all that apply).

- [ ] Walking [ ] Running [ ] Weights [ ] Other: _____

Do you have any barriers that limit your ability to safely exercise? Yes [ ] No [ ]

Please check all that apply

- [ ] Work [ ] Medical Condition [ ] Lack of Motivation [ ] Pain [ ] Family

Other: _____

CAFFEINE

Rank your caffeine intake:

☐ High ☐ Medium ☐ Low ☐ None

What do you typically drink during the day

☐ Water ☐ Juice ☐ Tea or Coffee ☐ Cola Other

How many cups per day? _____

ALCOHOL

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ☐ Beer ☐ Liquor ☐ Wine

How many drinks per week?

☐ 0 ☐ 1-3 x/week ☐ 4-6 x/week ☐ >6

DIET

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

How many meals do you eat on an average a day? _____

Rank your salt intake ☐ High ☐ Medium ☐ Low

Rank your fat intake ☐ High ☐ Medium ☐ Low

Please check the appropriate column for each of the following questions:

	Never	Rarely	Often	Almost Always
Does your family eat meals together?				
Do you read the food labels/nutritional information when you shop for food?				
Does your nutritional information influence your decision to buy/eat certain foods?				
Do you eat in front of a TV?				
Do you eat with others?				
Do you eat when you are stressed?				
Do you eat when you are anxious?				
Do you eat when you are lonely?				
Do you eat when you are not hungry?				
Do you eat when you are bored?				

Lifestyle

How many hours do you typically sleep at night? _____

How long does it typically take you to fall asleep? _____

How many times, on average, do you wake up once you fall asleep? _____

Do you wake up most mornings feeling well rested? _____

Has anyone ever told you that you snore?

Weight History

1. What is the main reason you decided to lose weight? _____
2. When did you begin gaining excess weight (give reasons if known)? _____
3. What do you think is the main cause of your weight problems?
4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.

_____

5. Is your spouse, fiancé, or partner overweight? _____
6. How often do you dine out? _____
7. List any food allergies: _____
8. What foods do you avoid? _____
9. What foods do you crave? _____
10. Do you awaken hungry during the night? _____
11. What are your worst food habits? _____
12. What are your snack habits? _____
13. Rate your body from 1 to 10. How would you describe your body? _____
14. If you could change one thing about your body, what would it be? _____
15. What do you feel will be your obstacle(s) to successful weight loss? _____
16. What is your typical breakfast? What time? Where? With whom? _____
17. What is your typical lunch? What time? Where? With whom? _____
18. What is your typical dinner? What time? With whom? _____
19. Add any additional comments you think would be helpful to the doctor. _____

_____

Do you have a personal or family history of blood clots or any clotting disorder? _____

If you answered yes to any of the preceding questions regarding the gallbladder, ovarian cyst or blood clots, please read the following statements and sign in acknowledgement:

Gallbladder of Gallstone Statement:

I understand that any pre-existing gallbladder dysfunction or gallstones I have (whether or not I am aware of it) may become exacerbated dur to the low-fat nature of the HCG Diet Program or as a consequence of the rapid weight-loss. This may result in the need to have my gallbladder surgically removed.

Patient Signature: _____ Date: _____

Ovarian Cyst / Polycystic Ovarian Syndrome Statement:

I understand that if I am predisposed to ovarian cysts or polycystic ovarian syndrome, there is an increased risk of a cyst rupture due to ovarian stimulation from the HCG hormone, which may or may not require surgery.

Patient Signature: _____ Date: _____

Blood Clots Statement:

I understand that HCG is a hormone that has the potential to increase the risk of blood clots in genetically susceptible people. If I have a personal or family history of blood clots, I accept this increased risk and agree to take aspirin and other recommended supplements to try to counteract the blood clot risk.

Patient Signature: _____ Date: _____

It is important to New You Wellness Center that you understand the risks and benefits associated with Pharmaceutical Weight Loss Therapy before beginning or continuing treatment.

If you have a history of cardiac problems, your provider may require clearance from your cardiologist prior to initiating treatment. Each patient's own risks can vary depending upon health history and lifestyle. It is important that you provide an accurate and complete medical history to your provider.

"This is my consent for New You Wellness Center including any physician, mid-level provider or nurse who works with the Physician Services, to begin treatment for Weight Loss or Hormone Replacement Therapy."

_____ I have read and understand that there may be complications arising from or related to treatment as described above and explained by my treating medical provider. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries , as well as my family history of diseases and conditions, with my provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

_____ I understand if any reactions or side effects occur, medication should be discontinued immediately, and I will seek appropriate medical attention.

_____ I understand that the physical exam by New You Wellness Center does NOT replace a full physical exam by my personal physician, and I agree to have my personal physician (not New You Wellness Center) perform a full physical exam including a lipid profile, cholesterol profile, and full metabolic panel, not less than annually.

_____ I understand that any pre-existing gallbladder dysfunction or gallstones I have (whether or not I am aware of it) may become exacerbated due to the low-fat nature of the HCG Diet Program or as a consequence of the rapid weight-loss. This may result in the need to have my gallbladder surgically removed.

_____ I understand that HCG is a hormone that has the potential to increase the risk of blood clots in genetically susceptible people. If I have a personal or family history of blood clots, I accept this increased risk and agree to take aspirin or other recommended supplements to try to counteract the blood clot risk.

_____ I further understand that not complying with the dosage recommendations and dietary restrictions could increase risks and alter my results from the program. If I do not follow these recommendations and restrictions, I agree to release New You Wellness Center and their medical providers and facility from any liability arising as a result of this.

_____ I understand how to take and administer and agree to take the exact dose prescribed by my provider.

_____ I understand that weight loss treatment is purely elective and that it may not be deemed medically necessary by insurance companies. Also, I understand that some of the recommended medications are not specifically approved by the FDA and may be used off-label.

_____ I understand that each patient is different and there are no guarantees as to results obtainable from treatment. Treatment is not a cure, and if I stop treatment, symptoms may return or worsen.

_____ I do not have and have not been diagnosed with "cancer". I am aware that therapy may awaken latent cancers, may promote metabolic disorders such as diabetes and may exacerbate the decline of other endocrine functions by changing and/or distorting essential hormone interactions.

Women Only

_____ I am not currently pregnant or breast feeding. If this changes, I will advise New You Wellness Center immediately.

_____ I understand that if I am predisposed to ovarian cysts or polycystic ovarian syndrome, there is an increased risk of a cyst rupture due to ovarian stimulation from the HCG hormone, which may or may not require surgery.

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at New You Wellness Center to obtain a blood sample for the purpose of determining specific laboratory test levels.

Consent to Obtain Medication History

I authorize New You Wellness Center to obtain my medication history from the e-prescribing network system. This information will be used by the providers of New You Wellness Center for the sole purpose of keeping a current and accurate listing of medications.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in New You Wellness Center's programs. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Patient Name: _____ Date: _____

Patient Signature: _____

Provider

I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete medical and health history and relevant family medical history. The patient has been provided the opportunity to ask questions concerning the risks, benefits, and alternatives to treatment, and desires to (circle one) commence / refuse treatment.

Provider Name: _____ Date: _____