VAIL MEDICAL CENTER & WEIGHT LOSS
13180 E COLOSSAL CAVE RD, STE 150, VAIL, AZ 85641

DEMOGRAPHICS

TODAY'S DATE: ____________________

LEGAL FIRST NAME: ______________________________________ MI: ____________

LEGAL LAST NAME: ____

PRIMARY PHONE: ____________________ ALTERNATE PHONE: ______________________

PHYSICAL ADDRESS: ____

MAILING ADDRESS (if different): ____

D.O.B: __________________ SEX: M F SOCIAL SECURITY #: ________-____-________

EMPLOYMENT STATUS: ____________ OCCUPATION: ____________________________

NAME AND ADDRESS OF EMPLOYER: ____

MARITAL STATUS: M S D W OTHER EMAIL: ____________________________________

NAME OF SPOUSE/PARENT/GUARDIAN: ____________________ PHONE: ____________

PRIMARY CARE PROVIDER: ____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER: ____

POLICY NUMBER: __________________ GROUP NUMBER: __________ PHONE: __________

POLICY HOLDER'S NAME: _________________________ POLICY HOLDER'S DOB: __________

RELATIONSHIP TO INSURED: ____

SECONDARY INSURANCE CARRIER: ____

POLICY NUMBER: __________________ GROUP NUMBER: __________ PHONE: __________

POLICY HOLDER'S NAME: _________________________ POLICY HOLDER'S DOB: __________

RELATIONSHIP TO INSURED: ____

EMERGENCY CONTACT

NAME: ______________________________________ PHONE: ____________________

RELATIONSHIP: ______________________________

NAME: ______________________________________ PHONE: ____________________

RELATIONSHIP: ______________________________

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PATIENT HEALTH QUESTIONNAIRE

Date: ____________________

Chief Complaint(s) or Concern(s) today: ____________________

____

Check if you are *currently suffering* from any of the following:

- Blurry vision
- Double vision
- Eye pain
- Ringing in ears
- Hearing loss
- Headache
- Urine leakage
- Tremor
- Numbness
- Weight loss
- Weight gain
- Fatigue
- Insomnia
- Abnormal bleeding
- Depression
- Mood swings
- Weakness
- Palpitations
- Chest pain
- Dizziness
- Nausea
- Joint pain
- Abdominal pain
- Diarrhea
- Constipation
- Shortness of breath
- Cough
- Wheezing

Other symptoms: ____________________

____

Past Medical History

Hospitalizations (why) or surgeries performed: ____________________ Year ________

____________________ ________

____________________ ________

____________________ ________

Check if you have been *diagnosed* with any of the following:

- Glaucoma
- Vertigo
- Migraines
- Tension headache
- Seizures/Epilepsy
- Herniated disk
- Thyroid disease
- Anemia
- Diabetes-adult onset
- Diabetes-juvenile
- Diabetes-pregnancy
- STD
- Hypertension
- High Cholesterol
- Heart Attack
- Heart disease/Angina
- Stroke
- TIA/Mini-Stroke
- Kidney disease
- Asthma
- Dementia
- Cirrhosis
- Kidney stones
- Valley Fever
- HIV/AIDS
- Osteoporosis
- Hepatitis B or C
- Blood Clots
- Enlarged Prostate
- Depression
- Anxiety
- Stomach ulcer
- Cancer - type ________
- Rheumatoid Arthritis
- Gout
- Substance abuse

Other diagnosis: ____________________

____

Family History (List all illnesses):

Mother: ______________________________ Living/Deceased (reason ______________)

Father: ______________________________ Living/Deceased (reason ______________)

Sibling: ______________________________ Living/Deceased (reason ______________)

Sibling: ______________________________ Living/Deceased (reason ______________)

Sibling: ______________________________ Living/Deceased (reason ______________)

Sibling: ______________________________ Living/Deceased (reason ______________)

Allergies

Medication allergies: ____

____

Environmental allergies: ____

____

Food allergies:

Please note that our meal replacements or injections may include one or more of the following items listed below. In order to help you avoid any allergic reaction, please indicate if you have any allergies to the items below. We will ensure to recommend products that are free of the items you have allergies to. If you have any adverse reactions to any of the food items or injections (Lipo B, B12) **please call our office immediately.**

Do you have any food allergies to the following?

Nuts	Yes ____	No ____
Soy	Yes ____	No ____
Gluten	Yes ____	No ____
Strawberries	Yes ____	No ____
Milk (not including lactose intolerant)	Yes ____	No ____
Sulfa and sulfa related materials	Yes ____	No ____
B12 vitamins	Yes ____	No ____
Unknown allergies to food	Yes ____	No ____

Other food allergies: ____

Patient Signature: ______________________________ Date: ______________

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Habits:

Smoker Y N If yes, amount per day ______________

Alcohol Y N If yes, amount per week ______________

Exercise Y N If yes, what type of exercise and amount per week ______________________________

Drugs Y N If yes, type ____

Women's Health:

Number of pregnancies ______________ Number of births ______________

Contraception currently in use ______________________________

or Hysterectomy: Partial or Complete What year? __________ Reason ______________________

Abnormal Pap(s) Y N Date of last pap smear ______________

Abnormal Mammogram(s) Y N When? Treatment? ______________________________

Date of last mammogram ______________ Date of last DEXA ______________

Current Medication:

Name/Strength (Prescribed/Vitamins/Herbs/Other)	Reason for Medication