

Medical History

(check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Abdominal Pains | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Night Restless legs |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Circulation problem | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Chest Pain or Pressure | <input type="checkbox"/> Loss of Sex Drive | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Difficulty with Erections | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Back or Neck Pains | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Stroke or Seizure |
| <input type="checkbox"/> Arm Pain or Weakness | <input type="checkbox"/> Asthma or Emphysema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Leg Pain or Weakness | <input type="checkbox"/> Anxiety Symptoms | <input type="checkbox"/> Low Blood Sugar |
| | <input type="checkbox"/> Depression | <input type="checkbox"/> Thyroid Problems |
| | | <input type="checkbox"/> Menstrual Problems |

Other Medical Problems _____

Other Medical Problems _____

Other Medical Problems _____

Surgical Procedures _____

Surgical Procedures _____

Currently smoking? Yes No If previous smoker, what year did you quit? _____

If Current smoker: _____ packs per day _____ number of years

On average, how many total drinks **per week** of beer, wine or other alcoholic beverages?

less than 1 1-5 6-10 11-15 16-20 >20

Recreational drug use? _____

History of Drug Abuse or Alcoholism? _____

Have you ever been the victim of any physical, sexual or psychological abuse? Yes No

Medication Allergies _____

Food Allergies _____

Current Medications and dosages

Non-prescription drugs _____

Vitamins, Herbs or Other Supplements _____

Women only: Are you pregnant/breast feeding? Yes No

Are you planning on getting pregnant? Yes No

Last Menstrual Period? _____ Irregular Menses? Yes No

Difficulty getting pregnant? Yes No n/a

Excess Hair Growth? Yes No

Family and Genetic History (check all that apply)

Please help us to understand your family background, as this information will help us to better understand your nutritional needs. This information is optional, but if provided will be held in strict confidence.

As best as possible, please list the original county(s) of origin or heritage of each side of your family.

Father's Family: _____

Mother's Family: _____

	Father	Mother	Paternal Grandparents	Maternal Grandparents	Siblings
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other _____
(Specify) _____

Medical Tests & Procedures (Please check & fill in approximate date)

- | | |
|---|---|
| <input type="checkbox"/> Complete Physical Exam _____ | <input type="checkbox"/> Colonoscopy _____ |
| <input type="checkbox"/> Exercise Stress Test _____ | <input type="checkbox"/> Mammogram _____ |
| <input type="checkbox"/> Echocardiogram _____ | <input type="checkbox"/> Pap Test _____ |
| <input type="checkbox"/> Carotid Ultrasound _____ | <input type="checkbox"/> Bone Densitometry Test _____ |

Weight History: Current Height _____ Current Weight: _____

(Estimate your average weight range for the time frames indicated)

_____ 16-20 years old
_____ 21-30 years old
_____ 31-40 years old

_____ 41-50 years old
_____ Over 50 years old
_____ Heaviest Weight/ When _____

(Diet and Nutrition History (Circle your answer)

How many meals do you eat in a typical day? 1 2 3 4 5 5+

How many snacks do you eat in a typical day? 1 2 3 4 5 5+

Do you skip meals? If yes, which ones? Yes No Breakfast Lunch Dinner

Do you plan your meals? Yes No

Have you ever been diagnosed with an eating disorder? Yes No

Have you ever had bulimia or anorexia? Yes No

What are your foods or type of food? _____

Are there any foods you will not eat? _____

Are there foods you can't stop eating once you start? _____

How many times a week do you eat out? (include take out) Breakfast Lunch Dinner

What types of restaurants? _____

What time of day does most of your eating occur?

Before 10am 10am-2pm 2pm-5pm 5pm-8pm after 8pm

Are you a slow or fast eater? Slow Fast Moderate

Are you distracted during meal times? Yes No

Do you eat in response to: Anger? Yes No Boredom? Yes No Stress? Yes No

Do you drink soda, juices, teas or other beverages?

Regular Yes No Type and how much? _____

Diet Yes No Type and how much? _____

How many 8oz glasses of water do you drink per day? _____

How many times a day do you move your bowels? _____

Please rate the following:	1	2	3	4	5
	Low		Medium		High
Will Power:	1	2	3	4	5
Self Esteem:	1	2	3	4	5
Binging:	1	2	3	4	5
Food Cravings:	1	2	3	4	5
Sugar Cravings:	1	2	3	4	5
Salt Cravings:	1	2	3	4	5
Commitment to losing Weight:	1	2	3	4	5

Previous Diet Experience: (Circle your answer)

How many times have you lost weight and gained it back? 1 2 3 4 4+

Have you tried any of these diets? Successful From Beginning? Successful Long Term?
Check all that apply: YES NO YES NO

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> My own diet: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Weight Watchers: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Jenny Craig | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Nutri System | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Atkins or Low Carb Diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Zone Diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Ornish Diet or Vegetarian Diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> South Beach Diet | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Liquid Diet (Slim Fast, Juices) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Optifast or Medifast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> OTC Diet Pills (Ephedra, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Prescription Diet Pills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Daily Routines:

What time do you eat breakfast? _____ What time do you eat lunch? _____ What time do you eat dinner? _____

Describe a typical breakfast: _____

Describe a typical lunch: _____

Describe a typical dinner: _____

Sleep Quality:

What time do you wake in the morning? _____ What time do you go to sleep at night? _____ On average how many hours do you sleep? _____

- | | | | | | | |
|--|------------------------------|-----------------------------|----------------------------|---|------------------------------|-----------------------------|
| Do you snore? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | ? <input type="checkbox"/> | Have you been told that you snore? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you ever choke or gag during sleep? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | Has someone seen you stop breathing while asleep? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you wake up tired in the AM? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | Do you wake during the night? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Does your spouse Snore? | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | How Often? _____ | | |
| | | | | For what reason? _____ | | |

Exercise and Fitness Survey:

How would you describe your daily activity level (based on your daily routine, not including scheduled exercise)

- | | |
|--|--|
| <input type="checkbox"/> Very Sedentary | <input type="checkbox"/> Moderate |
| <input type="checkbox"/> Sedentary to Moderate | <input type="checkbox"/> Moderate to Heavy |
| | <input type="checkbox"/> Heavy |

How often do you exercise?

Cardio (walking, running, biking, etc.)

- Rarely or never
- 1-2 times a week
- 3-4 times a week
- 5 or more times a week

Resistance (weights, lifting, etc.)

- Rarely or never
- 1-2 times a week
- 3-4 times a week
- 5 or more times a week

How long have you been regularly exercising? _____

Please describe your exercise routine: _____

Are there any exercises you've done in the past that you wish you could do now?

Have you ever worked with a personal trainer?

Yes

No

Do you find it hard to get motivated to work out?

Yes

No

Have you been restricted from exercise by a physician or other professional?

Yes

No

Why? _____

Have you ever been treated by a chiropractor or physical therapist?

Yes

No

Why? _____

Do you have any neck or back pains that restrict your exercise?

Yes

No

Describe: _____

Do you get any symptoms on exertion that restrict your ability to exercise?

Yes

No

Describe? _____

Do you have any leg or arm pains or weakness that restrict your exercise?

Yes

No

Describe? _____

I hereby affirm that I have answered these questions as completely and accurately as possible. I realize that failure to divulge any pertinent medical information may adversely affect my results in this program, and may result in injury or adverse outcomes.

Signature: _____

Date: _____

Print Name: _____



LEADING THE WAY TO BETTER HEALTH

Acknowledgement of Receipt of Notice of Privacy Practice

I have received a copy of the Notice of Privacy Practices for HealthBridge.

Name of Patient _____

Signature of Patient _____

Date _____

Signature of Patient Representative (required if the patient is a minor or an adult who is able to sign this form).

Relationship of Patient Representative to Patient _____



LEADING THE WAY TO BETTER HEALTH

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This office has always recognized the importance of privacy; this new federal law formalizes practices that have been followed routinely.

Background: In 1996, Congress recognized the need for national patient privacy standards and, as part of the Health Insurance Portability and Act, abbreviated as HIPAA, ordered that a set of rules be established to control how health information is used and disclosed, as maintained by doctors, hospitals and health plans. Health information is considered sensitive and personal, and the law establishes consumer protection and limits the sharing of such information, as do similar protections already enacted for bank accounts, credit cards and even video rentals.

- By the law, consent is not required to discuss your medical treatment with your other doctors or health care providers. This allows, also, for a prescription to be called into your pharmacy and for scheduling of surgery in a hospital.
- Additionally, none is needed in the course of carrying out health care operations, such as quality assessment, or in communication with your insurance carrier for payment related issues, or for incidental uses, such as announcing a name in a waiting room or use of sign-in sheets.
- However, this office has always gone one step further in protecting you and does not believe in releasing specific information about you to any business or governmental entity without your written consent.
- Specific authorization is required to disclose protected information in a non-routine circumstance, such as to your employer or for use in marketing a product to you.
- Medical information about you may be released for research and public health uses, as long as you are not individually identified.
- You are guaranteed access to review your medical record, and you may amend the record if you believe it to be incomplete for inaccurate.
- You have the right to review when and to whom your information was released
- You may suggest additional restrictions with regard to certain uses and disclosures, if you wish.
- Portions of this notice may be modified, as long as you are notified.
- Should you believe that your privacy rights have been comprised, you may report the violation, without penalty to you, to this office or to the Secretary of Health.
- The law requires that you acknowledge receipt of this notice.

HealthBridge
1165 Northern Blvd, #300
Manhasset, NY 11030
(516)627-4433 or (516)627-0303
Fax (516)627-0552

This notice is effective on or after April 14th, 2003



LEADING THE WAY TO BETTER HEALTH

Name: _____

Please **check and initial** all that apply:

- I give your facility authorization to leave “normal” test results on my answering machine or voicemail at home. _____
- I give your facility authorization to leave “normal” test results on my answering machine or voicemail at work. _____
- I give your facility authorization to give my spouse/significant other pertinent medical information, normal test results or medication change/information for myself. _____
- I give your facility authorization to give my spouse/significant other “abnormal” test results for myself. _____
- I prefer my primary number to be: Home ____ Office____ Cell ____
- I authorize your facility to E-mail me any test results, medication changes, requests or information. _____
- I DO NOT wish to receive any e-mails regarding updates, events or news related information pertaining to HealthBridge.
- I DO NOT authorize your office to use a post card without an envelope as a reminder of annual visits. _____

I hereby authorize payment of all authorized Medicare or other insurance medical benefits be made either to me or on my behalf to HealthBridge Primary Care (David G. Edelson, M.D)(William M. Klein, M.D) for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ **Date:** _____