

Houston Weight Loss & Low T

Confidential Patient Information

Patient Name:		Date:	
Address:		Apt:	
City, State		Zip:	
Email*:			
*By providing your email address you are agreeing to communication via email.			
Home Phone	<i>Primary contact</i> [<input type="checkbox"/>]	Work Phone	<i>Primary contact</i> [<input type="checkbox"/>]
		Cell Phone	<i>Primary contact</i> [<input type="checkbox"/>]
Date of Birth:		Age:	
		Sex:	Male Female
Employer:		Address:	
Whom may we contact in case of EMERGENCY?			
Name:		Phone:	
How did you hear about us? <input type="checkbox"/> Internet <input type="checkbox"/> Newspaper <input type="checkbox"/> Magazine <input type="checkbox"/> Friend / Patient referral _____ <input type="checkbox"/> TV / Infomercial <input type="checkbox"/> Billboards <input type="checkbox"/> Radio <input type="checkbox"/> Other _____			

Consent to Treat

I, the undersigned, hereby voluntarily consent and grant permission to J Bergeron MD PA, physician and employees to perform tests, treatment and any procedures as indicated at J Bergeron MD PA for myself or the above named minor, for as long as I am a patient at J Bergeron MD PA.

Signature of Patient or Personal Representative

Date

Consent to Email Lab Results

I consent to receiving my lab results via email at the above email address. I understand that my full name and date of birth will be listed on the results.

Signature of Patient or Personal Representative

Date

Consent to Photographs

I consent to photographs being taken for medical and diagnostic purposes. I understand these photos will not be used for any advertising and/or marketing purposes without my further written consent.

Signature of Patient or Personal Representative

Date

Occupational Hazard

In the event of an injury (i.e. needle stick) to an employee, that exposes any of my bodily fluids, at J Bergeron MD PA premises, I the undersigned, hereby voluntarily consent to give a blood specimen for testing.

Signature of Patient or Personal Representative

Date

Acknowledgement of Review of Notice of Privacy Practices and Patient Rights

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

Date

Name:		DOB:		Today's Date:	
SYMPTOMS: Please circle any of the following symptoms that you have now or have had recently.					
Nervousness / Anxiety	Sweats	Excessive thirst	Blurred vision		
Headache	Loss of weight	Hemorrhoids	Double vision		
Depression	Poor Appetite	Indigestion	Earache		
Dizziness	Bowel changes	Nausea	Loss of hearing		
Fainting	Constipation	Stomach pain	Nosebleeds		
Fever	Diarrhea	Vomiting	Ringing in ears		
Forgetfulness	Difficulty swallowing	Ringing in ears	Sinus problems		
Loss of sleep	Excessive hunger	Bleeding gums	Change in moles		
Chest pain	Bruise easily	Wheezing	Rash		
Irregular heart beat	Hives	Persistent cough	Sore that won't heal		
Swelling of ankles	Itching	Coughing blood	Painful urination		
Shortness of breath	Wheezing	Blood in urine			
Lack of bladder control	Frequent urination	Poor urinary stream			

Pain, weakness &/or numbness in the following:			
Arms	Hands	Feet	Neck
Back	Feet	Legs	Shoulders

Men Only:			
Breast Lump	Lump in Testicles	Erection Difficulties	Other: _____

Women Only:			
Last Menstrual Period?	_____	Date of Last Pap Smear?	_____
Date of Last Mammogram?	_____	Are you Pregnant? _____	# of Children _____

DIAGNOSES: Please circle if you have been diagnosed or treated for any of the following.			
AIDS	Chemical dependency	High cholesterol	Psychiatric disorders
Alcoholism	Chicken pox	High Blood Pressure	Rheumatic fever
Anemia	Diabetes mellitus	HIV positive	Scarlet fever
Anorexia	Emphysema	Kidney disease	Stroke
Arthritis	Epilepsy / Seizures	Measles	Suicide attempt
Asthma	Glaucoma	Migraine headaches	Thyroid problems
Bleeding disorders	Goiter	Mononucleosis	Tonsillitis
Breast lump	Gonorrhea	Multiple sclerosis	Tuberculosis
Bronchitis	Gout	Mumps	Typhoid fever
Bulimia	Heart disease	Pacemaker	Vaginal infection
Cataracts	Hepatitis	Pneumonia	Venereal disease
Prostate problem	Polio	Varicose veins	Ulcers – if yes, see below
Cancer Type: _____	Herpes Type: _____	Hernia: Type: _____	Ulcer: Type: _____

Name:

DOB:

Today's Date:

HOSPITALIZATIONS or SURGERIES			PREGNANCY HISTORY		
Date	Hospital	Reason for hospitalization/surgery	Year of	Boy or Girl	Outcomes / Type of Delivery

Have you ever had a blood transfusion? Yes No If yes, please give approximate dates:

HEALTH HABITS			OCCUPATIONAL CONCERNS		
Check (√) which substances you use and describe how much use			Check (√) if your work exposes you to the following		
	Caffeine			Stress	
	Tobacco	(packs/day)		Hazardous substances	
	Drugs			Heavy lifting	
	Alcohol	(drinks/week)		Contact with blood or body fluids	
	Other			Other	

FAMILY HISTORY: Fill in health information about your family.

Relation	Age	State of Health	Age of Death	Cause of Death	Check (√) if your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Obesity	
Mother					Asthma, Hay fever	
Brothers					Cancer and type	
					Chemical dependency	
					Diabetes	
					Heart disease, Strokes	
Sisters					High blood pressure	
					Elevated cholesterol	
					other	

WEIGHT HISTORY: (Diet Patients Only)

Weight Loss Programs	Lowest Weight/Age	Highest Weight/Age	RESULTS COMMENTS
None			
Jenny Craig			
Weight Watchers			
Medical Weight			
Atkins			
Other			

I certify that the above information is correct and complete to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:		Date:	
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Name:		Date of Birth:		Today's Date:	
Pharmacy Name:		Pharmacy Number:			
MEDICATIONS:	Dose	Number of Pills	How Often	For What	Discontinued Date
Example: <i>Calcium</i>	500 mg	1	2 times a day	Bones	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
ALLERGIES: Medications or substances		Symptoms/Reactions			
<input type="checkbox"/> No Known Allergies					
1.					
2.					
3.					
4.					
Changes since your last visit? If no, please initial and date below. If yes, please indicate above.					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					
Date/Initial					