West Coast Primary Care, LLC

*Account#*__________ *PATIENT INFORMATION*

Patient Name: ______________________ DOB: ___/___/_____ SS#: _____-_____-______ Sex: Male ___ Female ___

Address: ______________________________ City: ____________________ State: _______ Zip: __________

Phone#: (______) ____________________ Cell# (_______) ____________________

☐ Check this box if we may use this cell # for text and/or robocall appointment reminders

Nationality: ☐African American/Black ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Declined

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Email: ____

Pharmacy : ______________________________ Pharmacy Phone: (_____) _______-____________

Smoker? ☐Current Smoker ☐Former Smoker ☐Never Smoked

Primary Language: ____________________ Preferred method of contact: Email Phone Cell Phone Text
(Please Circle One)

Whom may we thank for referring you: ____

Employer Status: ☐Employed ☐Self-Employed ☐Retired ☐Disabled ☐Unemployed ☐Student

Occupation: ____________________ Employer ____________________

Employer Address ______________________________ Work Phone: (______) ______________

EMERGENCY CONTACTS

#1. Name: ____________________ Relationship: ______________ Phone#: (____) _______-__________

#2. Name: ____________________ Relationship: ______________ Phone#: (____) _______-__________

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________ Policy# ____________________ Group# ____________

Policyholder's Name: ______________________________ Date of Birth ____________________

Policyholder's SS#:: ____________________ Relationship to patient: ____________________

Claims Address: ____________________ City: ____________________ State: _____ Zip: ___________

Eligibility Phone# (_____) ______-________________

Secondary Insurance Carrier: ____________________ Policy# ____________________ Group# ____________

Policyholder's Name: ______________________________ Date of Birth ____________________

Policyholder's SS#:: ____________________ Relationship to patient: ____________________

Claims Address: ____________________ City: ____________________ State: _____ Zip: ___________

Eligibility Phone# (_____) ______-________________

Apr-15

WEIGHT CONTROL QUESTIONAIRE

The accompanying explanatory sheet discusses the importance of clearly delineating your expectations when participating in any kind of weight control program. This form has been designed to assist you in organizing your thoughts regarding exactly what it is you want for yourself. By first filling out this questionnaire as completely as possible, and then reviewing it with your physician, you will learn what can be reasonably expected to occur.

1.How did you hear about us? (Please circle all that apply to you)

St. Petersburg Times, Magazine, Radio, Goggle, MDBETHIN.COM, Patient, Friend, Doctor, Drive by, Facebook, Other____________________________________.

2. How much weight do you expect to lose?______________ Each Week?_________

Each Month?__________________.

3. Why do you want to lose weight? ____

____

4. How motivated are you to lose weight? On a scale from 1 – 10 (Ten being the most motivated). ______________.

5. What weight Loss Programs have you tried in the past? ___________________

____

5a. Where you successful? ____

____

5b. If yes, did you gain weight again? ______ If so, why?______________________

____

6. Do you exercise? ________ If yes, how often?____________________________

7. Do you drink Alcohol?______ If yes, what type? ___________________________

GREGORY NESTOR, M.D. *DEBORAH NOLAN, A.R.N.P.*

NAME________________ AGE________ SEX________ S M W D________

ADDRESS________________ PHONE________________ DATE________

NEXT OF KIN________________ ADDRESS________________

OCCUPATION________________ REFERRED BY________________

MEDICARE OR OTHER INSURANCE I.D.#________________ D.O.B.________________

WHAT MEDICAL DOCTOR DID YOU LAST SEE?________________ WHEN________________

1. What childhood illnesses have you had? ________________

2. Did you have any unusual or severe illnesses prior to age 18? ________________

3. Give the year or your age if you have had any of the following operations:

Tonsillectomy________	Hysterectomy________	Ear Operation________
Cataract Operation________	Prostate Operation________	Lung Operation________
Gall Bladder Removal________	Vein Operation________	Hernia________
Stomach Operation________	Appendectomy________	Artery Operation________
C-Section________	Eye Operation________	Heart________
Breast Surgery________	Hemorrhoidectomy________	Others________

4. If you have any of the following problems, please mark with an X:

Diabetes________	High Blood Pressure________	Prostate Problems________
Anemia________	Heart Trouble________	Lung Trouble________
Cancer________	Kidney or Bladder Trouble________	Stomach or Bowel Trouble________
Arthritis________	Female Problems________	
Depression________	Thyroid Problems________	

5. If you have had any broken bones, whether right or left, and the year in which the injury occurred:________________

6. Give the years and reason if you have been hospitalized for anything besides injuries or operation:________________

7. Except as noted above, for what have you been treated by physicians during the past ten years other than common colds and the like: ________________

8. What medicines do you now take and how often do you take them: ________________

9. Have you ever had a blood transfusion? ________ When? ________ How Many? ________

10. List any medicines to which you are allergic: ________________
    Have you ever had asthma or hay fever? ________________

(OVER)

11. Women Only: At what age did your periods commence?___
At what age did they stop?___
What if any trouble do you have with your periods?___

How many living children have you had? ___ How many still births? ___
How many miscarriages?___

12. a. Occupation ___ Are you retired?___
b. What is your spouse's age?___
c. Do you consider him/her to be in good health? ___ If not, why not? ___
d. In what year were you married? ___ How many beers, shots, cocktails and highballs do you consume in an average week?___
e. How many pipes, cigars, or packs of cigarettes do you smoke per day, on the average?___
f. How many cups of coffee do you drink per day?___ Tea ___
g. In what state were you born?___ If foreign born, at what age did you come to this country? ___ In what state did you live most of your life?___
h. Do you generally sleep well?___
i. What are your principal hobbies or recreational activities?___
j. If you were in the Armed Services, what branch and years? ___

13. LIVING / DECEASED

	Age	State of Health	Chronic Diseases	Age at Death	Cause of Death	Other Illnesses
Father						
Mother						
Brothers						
Sisters						
Children						

Except as noted, have any close blood relatives had cancer? ___

High Blood Pressure?___
Diabetes?___
Tuberculosis?___
Any disease that run in the family? ___

HOSPITAL DATA:

Admission Date:___ Admission Diagnosis: ___
Lab data:___