Capital Area Physician Weight & Wellness Center

Sree L. Gogineni, MD

2235 Cedar Ln #302
Vienna, VA 22182

44121 Harry Byrd Hwy #250
Ashburn, VA 20147

2010 B Opitz Blvd
Woodbridge, VA 20191

www.capwwc.com Ph: (703)255-6010 Fax: (703)255-6011

PATIENT REGISTRATION FORM

□ New □ Changes/Updates

PERSONAL INFORMATION

Patient's Last Name: _____ Middle: _____ First: _____

SSN#: _____ DOB: _____/_____/_____ Age: _____ Sex: ☐ F ☐ M Marital Status: ☐M ☐S ☐W ☐D

Race: _____ Ethnicity: (Check one) ☐ Hispanic ☐ Non-Hispanic ☐ Asian ☐ Black ☐ Caucasian ☐ Other

Home Address: _____ City: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

Local Pharmacy Name: _____ Telephone: _____

Pharmacy Address: _____ City: _____ State: _____ Zip: _____

Patient Email: _____ Preferred way of communication: _____

Emergency Contact Name: _____ Relationship: _____ Telephone: _____

Employer: _____ Occupation: _____

Employment Address: _____ City: _____ State: _____ Zip: _____

BILLING AND INSURANCE INFORMATION – We will request to scan your ID and insurance card.

1. Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: _____/_____/_____ SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

2. Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: _____/_____/_____ SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

3. Tertiary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Policy Holder's Name: _____ DOB: _____/_____/_____ SSN#: _____

Relationship to Insured: ☐SELF ☐SPOUSE ☐CHILD ☐OTHER_____

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WORKMAN'S COMPENSATION AND AUTO ACCIDENT-RELATED INFORMATION

Worker's Comp Name:_____Auto Insurance Company:_____

Date of Accident: _____Where:_____

Claim or File No._____Adjuster/Contact person name:_____

Adjuster/Contact person telephone:_____

HOW DID YOU HEAR ABOUT US?

Whom can we thank for the referral?

☐Physician ☐Insurance ☐Company ☐Family ☐Friend ☐ Internet ☐ Other: Name:_____

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HEALTH HISTORY QUESTIONNAIRE

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, M.I): ☐ M ☐ F **DOB:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
Previous or referring doctor:	Date of last physical exam:
Race: Ethnicity:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other _____

Immunizations and dates:	☐ Tetanus ☐ Hepatitis ☐ Influenza	☐ Pneumonia ☐ Chickenpox ☐ MMR *Measles, Mumps, Rubella*

List any medical problems you have been diagnosed with and when it was resolved, if applicable

SURGERIES

YEAR	REASON	HOSPITAL

OTHER HOSPITALIZATIONS

YEAR	REASON	HOSPITAL

Have you ever had a blood transfusion? **Yes** **No**

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HEALTH HISTORY QUESTIONNAIRE CONT'D

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Mild/Moderate/Severe	Type of Reaction

Non-Drug Allergies

Name the Drug	Mild/Moderate/Severe	Type of Reaction

MENTAL HEALTH		
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

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HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	Are you dieting?	☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?	☐ Yes	☐ No
	# Of meals you eat in an average day?		
	Rank salt intake: ☐ Hi ☐ Med ☐ Low		
	Rank fat intake ¨ Hi ¨ Med ¨ Low		
Caffeine	☐ None ☐ Coffee ☐ Tea ☐ Cola/Soda		
	# Of cups/cans per day?		
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
	If yes, what do you drink?		
	How many drinks per week?		
	Are you concerned about the amount you drink?	☐ Yes	☐ No
	Have you considered stopping?	☐ Yes	☐ No
	Have you ever experienced blackouts?	☐ Yes	☐ No
	Are you prone to "binge" drinking?	☐ Yes	☐ No
	Do you drive after drinking?	☐ Yes	☐ No
Drugs	Do you currently use recreational or street drugs?	☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?	☐ Yes	☐ No
Other	Do you have a method of Birth Control? If yes, specify:	☐ Yes	☐ No
	Do you take Stimulants/Pep Pills?	☐ Yes	☐ No
	Do you take Tranquilizers?	☐ Yes	☐ No
	Do you take Vitamins? If yes, specify:	☐ Yes	☐ No
	Do you take Laxatives?	☐ Yes	☐ No
	Do you take Sedatives/Sleeping Pills?	☐ Yes	☐ No
Smoking Status	Current Smoker ☐ Former Smoker ☐ Never Smoked ☐		
	☐Cigarettes – Per/Day ☐Chew - #/Day ☐Pipe - #/Day ☐Cigars - #/Day ☐Vape X/Day		
	☐How long? ☐How long since you've quit?		

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WOMEN ONLY

Age at onset of menstruation:	
Date of last menstruation:	
Period every _____days	
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes ☐ No
Number of pregnancies _____ Number of live births _____	
Are you pregnant or breastfeeding?	☐ Yes ☐ No
Have you had a D&C, Hysterectomy, or Cesarean?	☐ Yes ☐ No
Any Urinary Tract, Bladder, or Kidney Infections within the last year?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Any problems with control of urination?	☐ Yes ☐ No
Any hot flashes or sweating at night?	☐ Yes ☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around the time of your period?	☐ Yes ☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes ☐ No
Date of last pap and/or rectal exam?	

MEN ONLY

Do you usually get up to urinate during the night? If yes, # of times?	☐ Yes ☐ No
Do you feel pain or burning with urination?	☐ Yes ☐ No
Any blood in your urine?	☐ Yes ☐ No
Do you feel burning or have discharge from your penis?	☐ Yes ☐ No
Has the force of your urination decreased?	☐ Yes ☐ No
Have you had any Kidney, Bladder, or Prostate Infections within the last 12 months?	☐ Yes ☐ No
Do you have any problems emptying your bladder completely?	☐ Yes ☐ No
Any difficulty with erection or ejaculation?	☐ Yes ☐ No
Any testicle pain or swelling?	☐ Yes ☐ No
Date of last prostate and/or rectal exam?	

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PAST MEDICAL HISTORY

Have you ever had the following? If YES, provide age. If NO, leave blank.

Diphtheria	Yellow Jaundice
Chicken Pox	Pancreatitis
Measles	Gallbladder issues
German Measles	Diabetes Specify:
Mumps	High Blood Pressure
Mononucleosis	Stroke
Polio	Kidney Disease
Bronchitis	Bladder issues
Emphysema	Prostate issues
Asthma	Scarlet Fever
Hay Fever	Arthritis Specify:
Rheumatic Fever	Gout
Rheumatic Heart Disease	Bursitis
Angina Pectoris	Epilepsy, Seizures
Heart Attack	Migraine Headaches
Heart Failure	Nervous Breakdown
Heart Murmur	Syphilis
Hiatal Hernia	Gonorrhea
Ulcer	Glaucoma
Diverticulosis	Tuberculosis
Diverticulitis	Histoplasmosis, Sarcoidosis
Hemorrhoids	Herpes Specify:
Parasites (worms)	Anemia
Hernia	Broken Bones Specify:
Liver Disease	Cancer Specify:
Cirrhosis	Other:
Hepatitis	Other:
Thyroid Disease Specify:	Other:

ALLERGIES

Penicillin	☐ Yes ☐ No
Sulfa	☐ Yes ☐ No
Mycins	☐ Yes ☐ No
Morphine	☐ Yes ☐ No
Codeine	☐ Yes ☐ No
Latex	☐ Yes ☐ No
Other	
Other	

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FAMILY HEALTH HISTORY

MARK "X' IF YES, LEAVE BLANK FOR NO

Family Member	If Living, Age	Cancer	Thyroid Disease	Tuberculosis	Diabetes	Ulcer	Heart Disease	Stroke	High Blood Pressure	Kidney Disease	Liver Disease	Alcoholism	Epilepsy	Nervous Breakdown	Asthma	Hay fever	Allergies	Anemia	Blood Disease	Glaucoma	Migraine Headaches	Gout	Arthritis	If Dead, Age at Death	Cause of Death
Father																									
Mother																									
Brother(s)																									
Sister(s)																									
Spouse																									
Child(ren)																									

Cancer Type: _____

Arthritis Type: _____

Thyroid Type: _____

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Nutrition Evaluation:

Present weight: _____. Height (no shoes): _____. Desired weight: _____.

In what time frame would you like to be at your desired weight? _____.

Birth weight: _____. Weight at 20 years of age: _____. Weight 1 year ago: _____.

What is the main reason for your decision to lose weight? _____.

_____.

When did you begin gaining excess weight? (Give reasons, if known): _____.

_____.

What has been your maximum lifetime weight (non-pregnant) and when? _____.

_____.

Previous diets you have followed: Give dates & results of your weight loss: _____.

_____.

_____.

□ YES □ NO Is your spouse, fiancée, or partner overweight?
If yes, by how much is he or she overweight? _____.

How often do you eat out? Please specify: _____.

What restaurants do you frequently go to? Please specify: _____.

How often do you eat "fast foods"? Please specify: _____.

Who normally plans meals? _____. Who cooks? _____.

Who grocery shops? _____. Do you use a shopping list? □ YES □ NO

What time of the day and what day do you shop for groceries? _____.

_____.

□ YES □ NO Food allergies?
If yes, please specify: _____.

□ YES □ NO Food dislikes?
If yes, please specify: _____.

□ YES □ NO Foods you crave?
If yes, please specify: _____.

□ YES □ No Specific time of the day or month do you crave food?
If yes, please specify: _____.

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□ YES □ NO Do you drink coffee or tea?
If yes, how many cups a day: _____.

□ YES □ NO Do you drink soft drinks?
If yes, how many daily: _____. Diet or Regular: _____.

□ YES □ NO Do you drink alcohol?
If yes, how many cups a day: _____.

□ YES □ NO Do you use a sugar substitute?

□ YES □ NO Do you awaken hungry during the night?
If yes, what do you normally eat: _____.

What are your worst food habits: _____?

□ YES □ NO Do you binge eat?
If yes, how often: _____.

□ YES □ NO Have you ever induced vomiting or taken laxatives or diuretics for weight loss?

□ YES □ NO Have you ever been diagnosed with bulimia?

□ YES □ NO Have you ever been diagnosed with Anorexia Nervosa?

□ YES □ No Snack habits?

If yes, please specify: _____.

What time of day & how much: _____?

When you are under a stressful situation at work or family related, do you tend to snack more?

Explain: _____.

Do you think you are currently undergoing a stressful situation or emotionally upset?

Explain: _____.

Typical Breakfast: _____. What time: _____.

Where: _____. With whom: _____.

Typical Lunch: _____. What time: _____.

Where: _____. With whom: _____.

Typical Dinner: _____. What time: _____.

Where: _____. With whom: _____.

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Smoking habits: (answer only one)

□ You have never smoked cigarettes, cigars, or a pipe.
□ You quit smoking _____years ago and have not smoked since _____.
□ You quit smoking cigarettes at least one 1 ago and now smoke cigars or a pipe without inhaling smoke □ You smoke 30 cigarettes per day (1 and ½ packs)
□ You smoke 20 cigarettes per day (1 pack)
□ You smoke 40 cigarettes per day (2 packs)

Activity Level: (answer only one)

□ Inactive → No regular physical activity, with a sit-down job
□ Light activity → No organized physical activity during leisure time.
□ Moderate activity → occasionally in activities such as weekend golf, tennis, jogging, or swimming.
□ Heavy activity → consistent lifting, stair climbing, heavy construction, etc. or regular.
□ Vigorous activity → participation in extensive physical exercise for at least 1 hour 4 times per week.

Behavior Style: (answer only one)

□ You are always calm and easy going
□ You are seldom calm and persistently driving for advancement.
□ You are sometimes calm with frequent impatience.
□ You are hard-driving and can never relax

Current Symptoms (check any if present)

□ Low Appetite
□ Increased Appetite
□ Decreased Appetite
□ Chills
□ Fatigue
□ Fever
□ Sweats

Please describe your general health goals and improvements you would like to make: _____.

_____.

□ YES □ NO Do you feel you will need medication for appetite suppression?

□ YES □ NO Do you want vitamin B12 shots? (These are not given routinely, but many patients request them)

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Overall Health (check all that apply)

Eyes → last check up (date or how long ago) _____.
□ Blurred vision □ Double vision □ Cataracts □ Eye pain □ Redness
□ Glaucoma □ Recent change in vision

Ears → last check up (date or how long ago) _____.
□ Decreased hearing □ Pain □ Ringing □ Use of hearing device

Nose → □ Allergies □ Congestion □ Obstruction

Throat → □ Enlarged tonsils □ Snoring □ Sore throat □ Trouble swallowing

Cardiovascular → □ Chest pain or pressure □ Fainting or black out spells □ Heart murmur □ Palpitations (racing heart or skipped beats) □ Shortness of breath □ Trouble lying flat □ Swelling in the legs or feet

Respiratory → □ Congestion □ Cough □ Rattling □ Wheezing

Stomach & Gastrointestinal → Last colonoscopy (year) _____.
□ Bloody stools □ Cramps □ Constipation □ Diarrhea □ Heartburn or reflux
□ Nausea □ Pain □ Vomiting

Muscles, Joints, & Bones → □ Arthritis □ Back pain □ Morning stiffness
□ Muscle pain □ Muscle weakness □ Joint pain or stiffness (where): _____

Skin → □ Acne □ Itching □ Lump, nodule, or mole (where)_____
□ Nail changes _____ □ Rash (where) _____

Neurologic → □ Forgetfulness □ Numbness □ Weakness

Psychiatric → □ Anxiety □ Crying spells □ Depression □ Insomnia
□ Panic attacks □ Rage or temper problems □ Suicidal feelings

Hormones → □ Excessive hunger □ Excessive thirst □ Decreased libido
□ Hoarseness □ Recent hair growth

Hormones (Female) → Last Gynecological exam _____.
□ Change in periods □ Blood and circulation □ Clotting problems □ Easy bruising

Breast → Last mammogram _____.
□ Discharge □ Lump □ Pain □ Rash or redness

Allergy & Immunology → □ Frequent infection □ Seasonal allergies