

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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YES NO

Are you allergic to any medications?

If yes, please specify the medication(s) and reaction: _____

General Health History:

YES NO

History of high blood pressure?

YES NO

History of pre-diabetes or diabetes?

YES NO

History of heart attack or chest pain?

YES NO

History of swelling feet?

YES NO

History of frequent headaches or migraines?

If yes, list any medication for headaches/migraines: _____

YES NO

History of sleep apnea?

If yes, have you ever had a sleep study? Result: _____

YES NO

Do you snore?

YES NO

Have you been told you quit breathing while sleeping?

YES NO

Do you fall asleep while driving, riding in a car >30 min, reading, or watching TV?

If yes, describe: _____

YES NO

History of constipation (difficulty in bowel movement)?

YES NO

History of glaucoma?

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Past Medical History: (check all that apply and add any others in last 5 boxes in the last row)

| | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Cholera | <input type="checkbox"/> Anemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gallbladder disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Mumps | <input type="checkbox"/> Malaria | <input type="checkbox"/> Gout | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart valve disorder | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

Gynecologic History:

Number of Pregnancies: _____ . Dates: _____ .

Natural delivery or C-Section (specify): _____ .

YES NO Is there any chance of pregnancy now?

Complications of pregnancy (e. g. gestational diabetes, preeclampsia, eclampsia, etc.)

Describe: _____ .

Menstrual Onset Age: _____ . Regular: YES NO

If periods are not regular (not regular, excessively heavy, etc.), Describe: _____ .

_____ .

YES NO Is there any pain associated?

Last menstrual period: _____ .

YES NO Have you ever been diagnosed with polycystic ovary syndrome?

YES NO Hormone Replacement Therapy?

Please specify: _____ .

YES NO Birth Control Pills?

Specify Type: _____ .

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Last check-up: _____.

YES No Serious Injuries?

If yes, please specify: _____.

YES No Surgeries?

If yes, please specify: _____.

Family History:

| Relation | Age | Health/Disease | Overweight? | Cause of Death (if applicable) |
|----------|-----|----------------|-------------|-----------------------------------|
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Has any blood relative ever had any of the following?

YES NO Glaucoma
Please specify the relationship: _____.

YES NO Asthma
Please specify the relationship: _____.

YES NO Epilepsy
Please specify the relationship: _____.

YES NO High Blood Pressure
Please specify the relationship: _____.

YES NO Kidney disease
Please specify the relationship: _____.

YES NO Diabetes
Please specify the relationship: _____.

YES NO Tuberculosis
Please specify the relationship: _____.

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YES NO Psychiatric Disorder
Please specify the relationship: _____.

YES NO Heart disease/stroke
Please specify the relationship: _____.

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: _____ .

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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: _____.

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: _____ .

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Typical Dinner: _____ . What time: _____ .

Where: _____ . With whom: _____ .

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) _____ <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Cataracts <input type="checkbox"/> Eye pain <input type="checkbox"/> Redness <input type="checkbox"/> Glaucoma <input type="checkbox"/> Recent change in vision |
| Ears → last check up (date or how long ago) _____ <input type="checkbox"/> Decreased hearing <input type="checkbox"/> Pain <input type="checkbox"/> Ringing <input type="checkbox"/> Use of hearing device |
| Nose → <input type="checkbox"/> Allergies <input type="checkbox"/> Congestion <input type="checkbox"/> Obstruction |
| Throat → <input type="checkbox"/> Enlarged tonsils <input type="checkbox"/> Snoring <input type="checkbox"/> Sore throat <input type="checkbox"/> Trouble swallowing |
| Cardiovascular → <input type="checkbox"/> Chest pain or pressure <input type="checkbox"/> Fainting or black out spells <input type="checkbox"/> Heart murmur <input type="checkbox"/> Palpitations (racing heart or skipped beats) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Trouble lying flat <input type="checkbox"/> Swelling in the legs or feet |
| Respiratory → <input type="checkbox"/> Congestion <input type="checkbox"/> Cough <input type="checkbox"/> Rattling <input type="checkbox"/> Wheezing |
| Stomach & Gastrointestinal → Last colonoscopy (year) _____ <input type="checkbox"/> Bloody stools <input type="checkbox"/> Cramps <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn or reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Pain <input type="checkbox"/> Vomiting |
| Muscles, Joints, & Bones → <input type="checkbox"/> Arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Morning stiffness <input type="checkbox"/> Muscle pain <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Joint pain or stiffness (where): _____ |
| Skin → <input type="checkbox"/> Acne <input type="checkbox"/> Itching <input type="checkbox"/> Lump, nodule, or mole (where) _____ <input type="checkbox"/> Nail changes _____ <input type="checkbox"/> Rash (where) _____ |
| Neurologic → <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness |
| Psychiatric → <input type="checkbox"/> Anxiety <input type="checkbox"/> Crying spells <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Panic attacks <input type="checkbox"/> Rage or temper problems <input type="checkbox"/> Suicidal feelings |
| Hormones → <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Decreased libido <input type="checkbox"/> Hoarseness <input type="checkbox"/> Recent hair growth |
| Hormones (Female) → Last Gynecological exam _____ <input type="checkbox"/> Change in periods <input type="checkbox"/> Blood and circulation <input type="checkbox"/> Clotting problems <input type="checkbox"/> Easy bruising |
| Breast → Last mammogram _____ <input type="checkbox"/> Discharge <input type="checkbox"/> Lump <input type="checkbox"/> Pain <input type="checkbox"/> Rash or redness |
| Allergy & Immunology → <input type="checkbox"/> Frequent infection <input type="checkbox"/> Seasonal allergies |

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POLICIES ACKNOWLEDGEMENT AND AUTHORIZATION FORM

PATIENT INFORMATION

Last Name: _____ M.I.: _____ First Name: _____

Sex: F M

DOB: ____/____/____

Patient's Address: _____

Apt#: _____

State: _____ Zip: _____

Home Telephone: _____ Work Telephone: _____ Cell: _____

DECLARATION

I have read and understand the policies of the practice, and I agree to be bound by these terms. I also understand and agree that such terms may be amended from time to time by the practice.

'BEFORE' AND 'AFTER' PHOTOS

I GIVE PERMISSION for CAPWWC to take my 'before' and 'after' photos. (photos will not be used for advertising without patient permission)

I DO NOT give permission for CAPWWC to take my 'before' and 'after' photos.

Signature of Patient

Date

Print Name

Signature of Responsible Party/Guardian

Printed Name/Relationship