HCG Diet
Patient Information & Health Questionnaire

All information in this questionnaire will be kept completely confidential.

Name *(Last, First, M.I.):* ☐ M ☐ F

Address:

Street: _____

_____

City, State, Zip: _____

Email Address:: _____

Phone Numbers: (Check preferred)

☐ HOME: _____

☐ CELL#: _____

☐ WORK: _____

☐ OTHER:_____

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation:

BIRTHDATE:

Primary Doctor:

City/State/Phone #:

Date of last physical exam:

HOW DID YOU HEAR ABOUT US? Please be specific.

☐ Friend/Family: _____

☐ Doctor's Office: _____

☐ Advertisement: _____

☐ Drove by: _____

☐ Internet Search:_____

What term(s) did you search? _____

_____

☐ Facebook/Twitter:_____

☐ Other: _____

PERSONAL HEALTH HISTORY

MEDICAL HISTORY AND DATES OF DIAGNOSIS:

HAVE YOU HAD ANY RECENT BLOODWORK DONE, IF SO PLEASE LIST DATES, AS WELL AS WHO ORDERED IT? (I.E. LAB CORP, QUEST)

Surgeries:

Year	Reason	Hospital

Dr. Angelo Baccellieri, MD
914-703-4811

Other hospitalizations		
Year	Reason	Hospital

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

Name the Drug	Strength	Frequency Taken

Allergies to medications, foods, or supplements:

Name of Product	Reaction You Had	Name of Product	Reaction You Had

HEALTH HABITS AND SCREENING

Goal	What is your weight loss goal?		
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?		
Caffeine	☐ None ☐ Coffee, #cups _____ ☐ Tea	☐ Cola, # cans _____	
Alcohol	Do you drink alcohol?	☐ Yes	☐ No
Tobacco	Do you use tobacco?	☐ Yes	☐ No
Drugs	Do you currently use recreational drugs?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	

MENTAL HEALTH		
Do you have a history of substance abuse?	☐ Yes	☐ No
Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Have you been treated for depression?	☐ Yes	☐ No
Have you been treated for anxiety?	☐ Yes	☐ No
Have you been treated for bi-polar disorder?	☐ Yes	☐ No
Have you been treated for panic attacks?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have a history of an eating disorder?	☐ Yes	☐ No
Are you or have you been under psychiatric care?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
If you have answered 'Yes' to any of the above questions, please explain:		

WOMEN ONLY		
Date of last menstruation:		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Did you have nausea during your pregnancy?	☐ Yes	☐ No
Have you had a hysterectomy?	☐ Yes	☐ No
(REQUIRED FIELD) Date of last mammogram exam? Was it normal?		
(REQUIRED FIELD) Date of last pap exam? Was it normal?		

MEN ONLY
Date of last prostate exam?

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Can you come in for weekly follow-up visits?	☐ Yes	☐ No (if no, explain)

Acknowledgement of HIPPA
Privacy Notice & Disclosure

I agree that the practice may disclose certain health information to a family member, close personal friend or other caregiver, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

PHONE NUMBERS:	**WRITTEN COMMUNICATION:**
HOME: ☐ OK to leave message with detailed information ☐ OK to leave message with call-back number only **CELL#:** ☐ OK to leave message with detailed information ☐ OK to leave message with call-back number only **WORK:** OK to leave message with detailed information ☐ OK to leave message with call-back number only **OTHER:** ☐ OK to leave message with detailed information ☐ OK to leave message with call-back number only	☐ OK to mail to my home address ☐ OK to mail to my work/office address **HOME ADDRESS:** **STREET:** _____ _____ **CITY, STATE, ZIP:** _____ **WORK ADDRESS:** **STREET:** _____ _____ **CITY, STATE, ZIP:** _____

EMAIL: _____

☐ OK to email message with detailed information

I designate the following persons as persons approved by me to receive information about my medical treatment, due to my involvement of such persons with my health care or payment relating to my health care. I understand that I am not required to list anyone. I also understand that I may change this list at any time in writing.

Print Name:_____ Last four digits to his/her SS# (required):_____

Print Name:_____ Last four digits to his/her SS# (required):_____

Print Name:_____ Last four digits to his/her SS# (required):_____

The Privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for, Patient Health Information to the minimum necessary to accomplish the intended purpose. These provision do not apply to uses or disclosures made pursuant to an authorized requested by the patient, parent, guardian. Healthcare entities must keep a record of Patient Health Information disclosures. Information provided below will constitute an adequate record. Uses and disclosures for Treatment, Payment, and Health Care Operations may be permitted without prior consent.

Date of disclosure request	Disclosed to whom: address/fax #	Description of disclosure	Purpose of Disclosure	Dates of service of disclosure	Person completing request	Date completed

Received by:	**Date:**
Reviewed by:	**Date:**

I verify that the above is an accurate representation of my past and current health. HIPPA ACKNOWLEDGEMENT: I also verify that I have received a copy of the Notice of Privacy Practices regarding the use and disclosure of my private health information.

_____, _____, _____, _____

Name of Patient **Birthdate** **Signature of Patient (or Guardian)** **Today's Date**