**LUCKAY DOC PLLC**

**New Patient Information**

**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please tell us what you would like help with**

**Hormones\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_\_\_**

1. **PAST MEDICAL HISTORY**

Have you been diagnosed with any medical problems? If so please list them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been treated by a healthcare provider for anxiety, depression, or other mental health issues? Yes\_\_\_\_ No\_\_\_

Allergic to any medication or food?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Past Surgical History**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3.Current Medications Current Supplements/Vitamins**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current hormone replacement therapy? If so, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past hormone replacement therapy? If so, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4.Sleep History**

Do you have difficulty falling asleep ? Yes\_\_ No\_\_\_Staying asleep? Yes\_\_\_No\_\_

How long do you sleep?\_\_\_\_hours/night Do you wake up tired? Yes\_\_No\_\_

Do you snore? Yes\_\_ No\_\_ Do you have sleep apnea? Yes\_\_\_ No\_\_\_

**5. Weight History**

**If you are not concerned about your weight please skip this section**

When did you first begin to gain weight? As a child? \_\_\_\_\_; a teen? \_\_\_\_\_; a young adult? \_\_\_\_\_; at mid-life? \_\_\_\_\_\_\_\_. Please explain if none of these fit you\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the weight gain rapid? \_\_\_\_\_\_\_or slow? \_\_\_\_\_\_\_\_\_\_

Were other factors involved with the weight change such as stress?\_\_\_\_; marriage?\_\_\_\_\_\_\_;divorce?\_\_\_\_;illness?\_\_\_\_;medication?\_\_\_\_;abuse?\_\_\_\_; travel?\_\_\_\_;trauma?\_\_\_\_other?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What have you tried in the past to lose weight? a commercial program? \_\_\_\_; self-directed “popular” diet? \_\_\_\_\_\_\_\_; support group? \_\_\_\_; physician directed program? \_\_\_\_\_\_\_

What worked best for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What about it did you like and dislike? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What hasn’t worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why not? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you used any diet medications? \_\_\_\_\_\_\_When? \_\_\_\_\_\_\_\_\_\_\_\_\_What was it? \_\_\_\_\_\_\_\_\_\_\_Any problems with it? \_\_\_\_\_\_\_\_\_\_\_\_\_How did it work for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with and treated by a healthcare professional for an eating disorder such as bulimia; Binge Eating Disorder; Anorexia nervosa; or Night eating Syndrome? Yes\_\_\_ No\_\_\_

**6. SOCIAL HISTORY**

Are you employed?\_\_\_\_\_\_\_. If yes, where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At work do you move around or sit most of the time?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live alone or with someone?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you typically eat alone?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke/chew/dip?\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_Since how old?\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol?\_\_\_\_\_\_\_\_\_\_How often?\_\_\_\_\_\_\_\_\_How much?\_\_\_\_\_\_\_\_

Please tell us about any major life stresses\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been in an abusive relationship? Yes\_\_\_\_ No\_\_\_\_\_ If yes please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7.EXERCISE HISTORY**

What is your current physical activity level? Sedentary? \_\_\_\_\_\_\_\_\_\_, moderate? \_\_\_\_\_\_\_; active? \_\_\_\_\_\_\_\_\_

Identify a favorite activity you used to do in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any barriers to physical activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you spend your day? Chasing children?\_\_\_\_\_\_\_\_\_desk work?\_\_\_\_\_\_\_\_\_Active work?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. DIETARY HISTORY**

Do you eat at defined times?\_\_\_\_\_\_\_\_\_\_\_Or graze throughout the day?\_\_\_\_\_\_\_\_

What times of day do you eat?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your eating triggers? People?\_\_\_ places?\_\_\_; activites?\_\_\_; feeling such as stress, boredom, anger? Do you cook your meals?\_\_\_\_or eat out?\_\_\_\_\_\_\_\_

Are there any foods you can’t do without?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink soda/soft drinks?\_\_\_\_\_\_How many per day?\_\_\_\_Diet or regular? Do you drink tea?\_\_\_\_\_Sweet or unsweet? Do you use artificial sweetners?\_\_\_\_\_\_ Do you drink coffee?\_\_\_\_\_\_\_\_ How much per day?\_\_\_\_\_\_

**FOR WOMEN ONLY**

When did you first begin menstruating?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever been pregnant?\_\_\_\_\_

Any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last period?\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last Pap Smear?\_\_\_\_\_\_\_\_\_\_\_

History/Treatments for abnormal Pap? Yes\_\_ No\_\_

Do you have acne? Yes\_\_ No\_\_ PCOS? Yes\_\_ No\_\_

Fibrocystic breasts Yes\_\_ No\_\_ Uterine fibroids? Yes \_\_ No\_\_

Facial hair? Yes\_\_ No\_\_ Hair loss? Yes\_\_ No\_\_

What is your current birth control method?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR MEN ONLY**

Do you get up at night to urinate? Yes\_\_ No\_\_ Do you have difficulty starting a urine stream? Yes\_\_ No\_\_ When was your last prostate check?\_\_\_\_\_\_\_\_\_\_\_