WELCOME TO THE LIPID SERVICES OF THE TMH METABOLIC HEALTH CENTER!

New Patient Registration Information

1 - Please Print Out New Patient Registration Packet and the Personal History Questionnaire

2 - Complete the New Patient registration packet and the Personal Medical History sheets, Medication List, and Nutrition and Lifestyle Questions sheets.

3 - Return the forms to our office. The forms **must** be on file in our office **BEFORE** your appointment

**FORMS CAN BE RETURNED BY:**

- Mail to: TMH Metabolic Health Center- ATTN: Lipid Center, 2633 Centennial Blvd, Suite 100, Tallahassee, FL 32308
- Fax to : (850) 431-4711
- Hand deliver to office:
  Office is open Monday thru Thursday, 7:30 am to 5:30 pm; 8:00am – 12:00pm Friday

CALL IF YOU HAVE ANY QUESTIONS – (850) 431-5404
TMH Metabolic Health Center: Lipid Services
PERSONAL MEDICAL HISTORY

Patient Full Name: ________________________________ Date of Birth: __________________

Briefly describe your lipid problem:
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Have you taken any medications for high cholesterol or high triglycerides in the past? If yes, please list all and tell us why they were stopped.
_______________________________________________________________________________________________
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Write in the names of any disease you have had which required hospitalization. What year?
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Illnesses which you have had not requiring hospitalization. What year?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Serious injuries or accidents. What year?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Write in the names of any operations you have had. What year?
_______________________________________________________________________________________________
_______________________________________________________________________________________________

FAMILY MEDICAL HISTORY

How many brothers and sisters do you have? ____________ How many children do you have? ____________
Do any of your direct family members (Mom = M, Dad = D, Sister = S, Brother = B, Child = C) have or have been treated for these conditions? (Circle any that apply and check family member)

<table>
<thead>
<tr>
<th>Condition</th>
<th>M</th>
<th>D</th>
<th>S</th>
<th>B</th>
<th>C</th>
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<tr>
<td>HEART DISEASE</td>
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<td>STROKE</td>
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<td>HIGH CHOLESTEROL</td>
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<td>HIGH TRIGLYCERIDES</td>
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<td>POOR CIRCULATION</td>
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<td>BLOOD CLOTS</td>
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<td>DIABETES</td>
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<td>CANCER</td>
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<td>ALCOHOLISM/DRUG ABUSE</td>
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<td>HIGH BLOOD PRESSURE</td>
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<td>ARTHRITIS</td>
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<td>DEPRESSION</td>
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<td>EMPHYSEMA/ASTHMA</td>
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</table>

Patient Full Name: ________________________________ Date of Birth: __________________
YOUR PERSONAL HABITS

Do you smoke cigarettes or use tobacco? ____ If yes, how much per day? ____ How many years? ____
Did you smoke cigarettes in the past? ____ If yes, when did you stop smoking? ________________
Do you drink alcoholic beverages? If yes, how much? ________________________________
Do you snore excessively or wake yourself up at night? ________________________________
Do you feel drowsy in the morning or during the day? ________________________________
Have you ever been evaluated for sleep apnea? ________________________________
Do you use CPAP or other mechanical device for sleep apnea? ________________________________

FOR WOMEN

Are you still having regular monthly menstrual periods? | Yes | No
Have you gone through menopause? | Yes | No
Are you on estrogen replacement therapy? | Yes | No
Are you sexually active? | Yes | No
Are you currently pregnant or breastfeeding? | Yes | No

FOR MEN

Do you have loss of sexual activity? | Yes | No | How long?
Are you having erectile dysfunction (ED)? | Yes | No | How long?
Do you have prostrate trouble? | Yes | No | How long?

FOR WOMEN AND MEN

Are you currently having problems with any of the following?

Do you frequently have severe headaches? | Yes | No
Do they cause visual trouble? | Yes | No
Do they occur on one side of the head? | Yes | No
Do they hurt most in the back of the head and neck? | Yes | No
Do you have spells of dizziness? | Yes | No
Have you ever fainted? | Yes | No
Do you have ringing in the ears? | Yes | No

Have you ever had any of the following?

convulsions? | Yes | No
nosebleeds? | Yes | No
transient loss of vision in one eye or double vision? | Yes | No
spells of weakness in your arms of legs? | Yes | NO
TIA (transient ischemic attack)? | Yes | No

Have you ever had shortness of breath:

Doing your usual work? | Yes | No
Climbing a flight of stairs? | Yes | No
That awakens you at night? | Yes | No
That causes you to cough? | Yes | No
Accompanied by wheezing? | Yes | No
Have you ever coughed up blood? | Yes | No
Do you cough up much sputum? | Yes | No

Patient Full Name: __________________________ Date of Birth: ________________
Have you ever had chest pain or tightness in the chest which begins:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>When exerting yourself?</td>
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<td>When walking against a wind?</td>
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<td>When walking up a hill?</td>
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<td>After a heavy meal?</td>
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<td>When upset or excited?</td>
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<td>With palpitations?</td>
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<td>Radiates down the arm?</td>
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<td>Disappears if you rest?</td>
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<td>Occurs only at rest?</td>
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<td>When walking fast?</td>
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<td>When walking in cold weather?</td>
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<td>Do you sleep on more than one pillow?</td>
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</table>

If you have chest pain or tightness, please explain: ____________________________

Have you recently had pain in the stomach which:

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<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Occurs 1 - 2 hours after a meal?</td>
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<td>Is brought on by eating friend foods, gassy foods?</td>
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<td>Awakens you at night?</td>
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<td>Is relieved by antacid medication?</td>
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<td>Is relieved with milk or eating?</td>
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<td>Occurs while eating or immediately after?</td>
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Have you recently had:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>A change in bowel habits?</td>
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<td>Crampy pain in the abdomen?</td>
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<td>Alternating diarrhea and constipation?</td>
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<td>Blood in the stool?</td>
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<td>Black stools?</td>
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<td>Trouble swallowing?</td>
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<td>Require use of strong laxatives or enemas?</td>
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Have you had:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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<td>Dark colored urine?</td>
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<td>Getting up frequently at night?</td>
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<td>Passed a kidney stone?</td>
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Have you been feeling down, depressed or hopeless recently?               |     |    |

Have you experienced little interest or pleasure in doing things in the past 2 weeks? | Yes | No |

Abuse is identified as a nationwide problem and health concern. We are required to ask you the following: Are you in a relationship where you are being threatened or hurt? _____Yes  _____No

USE THIS SPACE TO PROVIDE ADDITIONAL INFORMATION: (You may add additional pages if needed.)

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Rev 7/23/14
# PATIENT MEDICATION and SUPPLEMENT LIST

Name: ____________________________  DOB: ____________  Physician: ____________________________

Pharmacy: ________________________________________________________________

Medication Allergies: ________________________________________________________

<table>
<thead>
<tr>
<th>Medication name</th>
<th>Dose</th>
<th>Taken by</th>
<th>Frequency (times per day)</th>
<th>Medication used for</th>
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Reviewer Signature/Date/Time

_______________________________  ________________________________

_______________________________  ________________________________

_______________________________  ________________________________

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**Notice to Patient**  Keep an updated medication list with you at all times in case of emergency situations. Update the information when medications are changed or discontinued. If you have been seen for a consult, give a copy of your medication list to your primary Care Physician.
TALLAHASSEE MEMORIAL LIPID CENTER

Nutrition and lifestyle questions

Patient name_______________________________DOB________________________

HABITS

Have you been advised to be physically active by your physician? □ NO □ YES

Are there restrictions on your exercise? __________________________________________

Please rate your activity level: □ Mild □ Moderate □ Active

Do you have a regular exercise program? □ NO □ YES

Do you smoke or chew tobacco? □ NO □ YES, # per day: ______________________

Do you use recreational drugs (marijuana, _________)? □ NO □ YES, how often: ______

Alcoholic drinks per week: __________________________

NUTRITION

Has your weight changed in the last year? □ Gained: _____ □ Lost: _____ □ Goal weight: _____

Are you allergic to any foods? □ NO □ YES, specify: ______________________________________

Have you changed your eating habits since finding out that you have high cholesterol or triglycerides? □ NO □ YES

Are you following a diet? □ NO □ YES: _________________________________________________

Please list your experience with diets in the past: _________________________________________

_________________________________________________________________________________

How often do you eat out: Per Week? _______________ Per Month? _____________________

Have you identified problems with your eating habits? _____________________________________

Please describe what you eat on a typical day…

Breakfast – Time: _____ AM/PM Food/Drink: __________________________________________

Lunch – Time: _____ AM/PM Food/Drink: __________________________________________

Dinner – Time: _____ AM/PM Food/Drink: __________________________________________

Snack(s)- Time: _____ AM/PM Food/Drink: __________________________________________
Patient name_______________________________DOB________________________

Have you ever seen a Dietitian?__________________________________________

Who usually prepares the food? ___________________________________________

Who does the food shopping?____________________________________________

Please check approximately how often you eat the following foods:

High fat meats like sausage, bacon, hot dogs and ribs:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Whole milk, cream, cheese, ice cream:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Fish:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

How is your fish usually cooked?__________________________________________

Sweets like candy, cakes, cookies, pies:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Vegetables like greens, broccoli, lettuce, cabbage, green beans, and carrots:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Whole grains like oatmeal, cheerios, whole wheat bread or brown rice:
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Do you drink sugar sweetened drinks like soda, Gatorade, Kool-Ade or sweet tea?
☐ Almost every day  ☐ 2-3 times/week  ☐ once/week  ☐ occasionally  ☐ Never  ☐ other_____

Please circle which of the following you use at all:   butter, stick margarine, soft tub or squeeze margarine

If you drink coffee, what do you usually add to it?________________________________

Please specify any religious/cultural or personal health beliefs that you would like considered as we work with you:  _____________________________________________________________________________________

How do you learn best?  ☐Reading  ☐Listening  ☐Demonstration  ☐Hands-on  ☐Other:_______________

Thank you for answering these questions. Our dietitian will discuss your eating habits with you and provide instructions to help improve your lipids.