TALLAHASSEE MEMORIAL LIPID CENTER
2633 CENTENNIAL BLVD, SUITE 100
TALLAHASSEE, FLORIDA 32308
PHONE (850) 431-5404 ~ FAX (850) 431-4711

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.

_____
_____
_____
_____

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)

	M	D	S	B	C		M	D	S	B	C
HEART DISEASE						CANCER					
STROKE						ALCOHOLISM/DRUG ABUSE					
HIGH CHOLESTEROL						HIGH BLOOD PRESSURE					
HIGH TRIGYLCERIDES						ARTHRITIS					
POOR CIRCULATION						DEPRESSION					
BLOOD CLOTS						EMPHYSEMA/ASTHMA					
DIABETES											

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:

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

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

Have you recently had pain in the stomach which:

Occurs 1 - 2 hours after a meal?	Yes	No
Is brought on by eating friend foods, gassy foods?	Yes	No
Awakens you at night?	Yes	No
Is relieved by antacid medication?	Yes	No
Is relieved with milk or eating?	Yes	No
Occurs while eating or immediately after?	Yes	No

Have you recently had:

A change in bowel habits?	Yes	No
Crampy pain in the abdomen?	Yes	No
Alternating diarrhea and constipation?	Yes	No
Blood in the stool?	Yes	No
Black stools?	Yes	No
Trouble swallowing?	Yes	No
Require use of strong laxatives or enemas?	Yes	No

Have you had:

Dark colored urine?	Yes	No
Getting up frequently at night?	Yes	No
Passed a kidney stone?	Yes	No

Have you been feeling down, depressed or hopeless recently?	Yes	No
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.)

_____

_____

_____

_____

For Office Use Only
ICD-9 Code:_____

PATIENT MEDICATION and SUPPLEMENT LIST

Name:_____ DOB:_____ Physician:_____
Pharmacy:_____
Medication Allergies:_____

Medication name	Dose	Taken by	Frequency (times per day)	Medication used for
		□ mouth □ injection □ inhaled □ _____		
		□ mouth □ injection □ inhaled □ _____		
		□ mouth □ injection □ inhaled □ _____		
		□ mouth □ injection □ inhaled □ _____		
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Reviewer Signature/Date/Time

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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.