SCS WeightLoss & Wellness System™

Office Use Only
Chart:_____Date:_____Entered:_____By:_____

Patient Registration:

Last Name:_____ First Name:_____Middle:_____

Address:_____

City:_____State:_____Zip:_____

Hm Phone:(___)_____ Cellular:(___)_____Work:(___)_____

Email:_____

Gender:____ M____F Birth Date:___/___/_____ SSN:_____

Occupation:_____Employer:_____

Emergency Contact:

Local Name:_____ Phone: _____

Relationship:_____

Contacting You:

May we call you? YES NO

May we email you? YES NO

May we mail you? YES NO

SCS WeightLoss & Wellness System™

Insurance Information:

Medical insurance policies do not typically cover weight management care and related expenses, including laboratory testing, electrocardiograms, prescription medication and related supplements. If your primary diagnosis is obesity, you may not bill your insurance company for a co-morbid condition. Doing so may result in a charge of fraud against you.
An appropriate receipt of payment will be provided, including charges and descriptions of the office visit for the different levels of service provided. The codes used for this purpose may not correspond to the codes used by insurance companies.

Changes to "codes" will not be made for the use of any insurance company. Please understand, SCS Physicians WeightLoss System of SW Broward, LLC., will not present a bill to any insurance company for weight management serviced or related charges and is not obligated to complete any form that may be provided by a health insurance company sent to the patient or physician in this regard.

Supplement Pill Container:

You may receive a supplement pill container as part of your patient starter kit or as a separately sold item. This container is not approved for storing controlled substances, such as prescribed medications. All prescribed medication must remain in their originally labeled bottle.

Patient Statement of Understanding:

I have read and fully understand the above information related to insurance and participation in SCS Physicians WeightLoss System of SW Broward, LLC. I have also had the opportunity to ask questions regarding these issues. I am aware that this weight management care and related expenses are not covered by medical insurance and I am personally responsible for all payments at time of service. I understand the specifics of these limitations as described in this document. I accept these specific policy rules.

Patient Name_____(Print)

Patient Signature_____ Date_____

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For Office Use Only

Date:_____ Start Weight:_____ Goal Weight:_____

Patient History:

All questions in this history are strictly confidential and will become part of your medical record on file.

Last Physical:_____ Last EKG:_____ Last Eye Exam:_____

Health History: please check all that pertain to you personally

- ○ Alcohol Abuse
- ○ Anemia
- ○ Arthritis
- ○ Asthma
- ○ Autoimmune Disease
- ○ Bleeding Disorder
- ○ Bloody Stool
- ○ Bronchitis
- ○ Cancer
- ○ Chest Pain
- ○ Constipation
- ○ Convulsions
- ○ Depression
- ○ Diabetes
- ○ Diarrhea
- ○ Dizzy Spells
- ○ Drug Abuse
- ○ Eating Disorder
- ○ Epilepsy
- ○ Fainting Spells
- ○ Fatigue
- ○ Frequent Urination
- ○ Gallbladder Disorder
- ○ Glaucoma
- ○ Headaches
- ○ Heart Disease
- ○ High Cholesterol
- ○ Hypertension
- ○ Insomnia
- ○ Irregular Pulse
- ○ Kidney Disease
- ○ Liver Disease
- ○ Lung Disease
- ○ Mental Illness
- ○ Migraines
- ○ Moodiness
- ○ Nervousness
- ○ Obesity
- ○ Palpitations
- ○ Rashes
- ○ Shortness of Breath
- ○ Stroke
- ○ Thyroid Disease
- ○ Other

Surgeries / Hospitalizations:

Year Reason / Diagnosis

_____
_____
_____
_____
_____

Medication Allergies:

Medication Reaction

_____
_____
_____
_____
_____

List ALL Medications and Over-the-Counter drugs, Dietary supplements, Vitamins, Herbs, Inhalers, etc. you are currently taking or have taken in past 6 months:

Medication Strength Frequency

_____
_____
_____
_____

Personal Habits & Behaviors:

Diet -
Are you dieting? YES NO
If yes, are you on a physician-prescribed medical diet? YES NO
Have you taken physician-prescribed or over-the-counter appetite suppressants within the past 6 months? YES NO
How many meals do you eat in an average day? 1-3 4-6 7-10
Rank your salt intake: HIGH MEDIUM LOW
Rank your fat intake: HIGH MEDIUM LOW
Rank your carbohydrate intake: HIGH MEDIUM LOW

Beverages -
What types of caffeine do you drink? COFFEE TEA SODA
How many cups/cans per day? 0 1-3 4-6 7-10
Do you drink water daily? YES NO
How many (8 oz.) glasses? 0 1-3 4-6 7-10

Do you drink alcohol? YES NO
If yes, what kind? LIQUOR WINE BEER
How many drinks per week? 1-2 3-5 5-10 10++

Tobacco & Drugs -
Do you smoke cigarettes? YES NO
If yes, how many packs per day? LESS THAN 1 1-2 MORE THAN 2
How many years have you smoked?
If you previously smoked, what year did you quit?
Do you currently use recreational or street drugs? YES NO

Exercise -
Which best describes your current mode of exercise?
SEDENTARY (no exercise)
MILD (climb stairs, walk, golf, light housework - for 15 minutes)
OCCASIONAL VIGOROUS (walk, bike, tennis, dance - for 30 minutes less than 4 times per week)
REGULAR VIGOROUS (aerobic activity - for more than 30 minutes, more than 4 times per week)

Sex -
Are you sexually active? YES NO
If yes, do you use a contraceptive method? YES NO
Are you trying for a pregnancy? YES NO

Women Only:

Date of last menstruation

Are you pregnant, trying for a pregnancy, or breast feeding? YES NO

Weight History: **Please answer as completely as possible**

What is the main reason you decided to lose weight?

Have you attempted to lose weight in the past? With success? Without success?

What do you think is the main cause of your weight problems?

Is your spouse or partner overweight?

Do you like to cook? If yes, what types of food do you prepare?

How often do you dine out? Breakfast? Lunch? Dinner?

What restaurants do you prefer?

What foods do you crave?

What foods do you dislike?

What do you consider your worst food habits?

List any food allergies:

Do you awaken hungry during the night?

How would you describe your body? Rate your body from 1 to 10.

What do you like most about your body?

What do you like least about your body?

What do you anticipate will be your obstacle(s) to successful weight loss?

Do you drink water before, during or after meals?

Do you eat bread before, during or after meals?

Do you drink alcohol before, during or after meals?

Describe your typical breakfast – include time, place and with whom:

Describe your typical lunch – include time, place and with whom:

Describe your typical dinner – include time, place and with whom:

What time of day are you most hungry?

Add any additional comments and concerns, you think would be helpful in establishing your weight loss plan.

Accuracy Agreement:

I hereby agree that the information I have provided in this medical history is accurate to the best of my knowledge.

Patient Name_____(Print)

Patient Signature_____ Date:_____

Thank you for your time and patience in completing this form. This information will assist your doctor and SCS staff, in gathering your medical history, identifying potential challenges and supporting your weight management success as you embark on the SCS Physicians WeightLoss System.