Sunrise Health Medical Group, Inc.

The following information is necessary for our staff to determine your eligibility for our programs and to establish your best course of action. Please answer all questions to the best of your knowledge. All information is kept strictly confidential.

Initial Problem List
(for Physician's use)

I. PERSONAL INFORMATION Birthdate________________________

Name ______________________ Daytime Phone ______________________

Address____

City________________ Zip________ Bus. Phone________________

Ht.________ Age______ Occupation______________________

Spouse's Name________________ Spouse's Occupation________________

II. HEALTH HISTORY

1. Personal physician____________________ Date of Last Exam____________________

2. Have you ever experienced symptoms or been treated for any of the following?

	Yes	No	Year		Yes	No	Year
Cancer	O	0	____	Stroke	0	0	____
Liver Disease (Hepatitis)	0	0	____	Thyroid Disease	0	0	____
Kidney Disease	O	O	____	Bladder Disease	0	0	____
G.I.Disturbances (such as Ulcer, Colitis,Diverticulitis	O	O	____	Arthritis (Gout Rheumtism)	0	0	____
Heart Disease(chest pain High blood pressure)	O	O	____	History of Anorexia Nervosa/Bulimia	0	0	____
Heart Murmur	O	O	____	Migraine Headaches	0	0	____
Depression	0	0	____	Constipation	0	0	____
Drug Abuse	0	0	____	Gallbladder Disease	0	0	____
Diabetes	0	0	____	High Cholesterol	0	0	____
Glaucoma	0	0	____	Anemia	0	0	____
Low Blood Sugar/Fainting	0	0	____	Cortisone Therapy	0	0	____
Low Back Pain/Neck pain	0	0	____	Epilepsy	0	0	____

3. Medications you are taking now: ____

____

4. Known Allergies: ____

5. Are you under a physician care for a any acute or chronic condition(s)? Yes No
   If Yes, what?

____

____

6. Have you had surgery(s)? Yes No

If Yes, what kind? ____

____

7. Are you currently pregnant or breast feeding? Yes No

8. Are you currently taking Fertility Drugs? Yes No

9. Are you currently under the care of a Psychiatrist? Yes No

III. WEIGHT RELATED HISTORY

1.Previous methods of weight reduction and results ____

____

____

2.How long have you been overweight?____

3.What is your highest weight in adulthood? _________________ When?____

4.What is your lowest weight in adulthood? ___________________ When? ____

5.What was your weight one year ago?____

6.What is your average weight in adulthood? ____

7.What was your weight at age 18 _________________________

8.What would you like to weigh? __________________________

9.Why do you want to lose the weight at this time? ____

10.How long have you been thinking about losing weight? ____

11.What do you do for exercise? ____

12.Has your physician recommended that you lose weight? Yes No Why?____

13.Are you having any physical discomforts that you attribute to weight? ____

____

____

Smoke? Yes No If yes, how much?____

Use of alcohol? Yes No If yes, how much? ____

Single/Married/Divorced/Widow: Children: ____

Family history of obesity. Check only if Yes
Husband( ) Wife( ) Father( ) Mother( ) Brother( ) Sister( ) Daughter( ) Son( )

Family Medical history: Check only if Yes
Heart Disease( ) Diabetes( ) Hypertension (high blood pressure)( )

The above information is accurate to the best of my knowledge. I understand it will be kept strictly confidential.

Signature:____ Date_________________________________