# VIRGINIA BEACH SURGERY CENTER
# DENTON D. WEISS, MD, FACS

## Health Information

(Please Print Legibly & Fill In or Correct All Fields)

| | | | | | |
|---|---|---|---|---|---|
| **Name:** | | Height: | Inches | Age: | |
| **Date:** | | Weight: | Lbs | BMI: (*Nurse will calculate)* | |

| **Physicians** | Name | Phone | **Allergies** |
|---|---|---|---|
| PCP | | | 1 |
| Cardiologist | | | 2 |
| Endocrinologist | | | 3 |
| OB/GYN | | | 4 |
| Urologist | | | 5 |
| **Pharmacy** | | | 6 |

| **Medication and Supplement Names** | Dose | **Surgical History Procedures** | Date |
|---|---|---|---|
| 1 | | 1 | |
| 2 | | 2 | |
| 3 | | 3 | |
| 4 | | 4 | |
| 5 | | 5 | |
| 6 | | 6 | |
| 7 | | 7 | |
| 8 | | 8 | |
| 9 | | 9 | |

**Medical History**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS / HIV | No | Yes | Facial Pain | No | Yes | History of Ear Infections | No | Yes |
| Arthritis | No | Yes | Fibromyalgia | No | Yes | History of Strep Throat | No | Yes |
| Asthma / Allergies | No | Yes | Gastric Bypass | No | Yes | Kidney Problems | No | Yes |
| Auto Immune Disease | No | Yes | Goiter / Thyroid | No | Yes | Liver Disease (hepatitis, fatty liver, cirrhosis) | No | Yes |
| Blood Clots / DVT | No | Yes | Headaches / Migraines | No | Yes | Mental Health Disorder | No | Yes |
| Cancer | No | Yes | Heart Attack / Chest Pains | No | Yes | Polycystic Ovary Disease | No | Yes |
| Claustrophobia | No | Yes | Heart Murmur / Palpitations | No | Yes | Pneumonia / Lung Problems | No | Yes |
| Cold Sores / Herpes / Shingles | No | Yes | Blood Disorder | No | Yes | Sensitivity to Cold (numbness in fingertips) | No | Yes |
| Depression | No | Yes | Hepatitis | No | Yes | Sinus Problems / Infections | No | Yes |
| Diabetes | No | Yes | High Blood Pressure | No | Yes | Stroke | No | Yes |
| Dizziness / Vertigo | No | Yes | High Cholesterol | No | Yes | Ulcers | No | Yes |
| Epilepsy / Seizures | No | Yes | History of Bronchitis | No | Yes | Urinary Issues | No | Yes |

Other(s):

***Please give diagnosis dates and explanation to any of the 'Yes' answers above.***

**Family History**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Alzheimer's | No | Yes | Diabetes | No | Yes | Lung Problems | No | Yes |
| Anesthesia Problem | No | Yes | Gynecomastia | No | Yes | Leg Ulcers | No | Yes |
| Arthritis | No | Yes | Edema | No | Yes | Migrains | No | Yes |
| Asthma / Allergies | No | Yes | Heart Disease | No | Yes | Ostoporosis | No | Yes |
| Blood Clots | No | Yes | Heart Surgery | No | Yes | Psoriasis | No | Yes |
| Blood Disorder | No | Yes | Hepatitis | No | Yes | Stomach Problems | No | Yes |
| Cancer | No | Yes | High Blood Pressure | No | Yes | Varicose Veins | No | Yes |
| Depression | No | Yes | High Cholesterol | No | Yes | Venous Insufficiency | No | Yes |
| Dermatitis / Eczema | No | Yes | Kidney Disease | No | Yes | Other: | No | Yes |

**Patient Name: «Person_First_Name» «Person_Last_Name»** **Date: «Appointment_Date»**

## Nutrition

| | | |
|---|---|---|
| Eating out: | _____ | average # of times per week |
| Vegetables | _____ | average # of servings per day |
| Fruits: | _____ | average # of servings per day |
| Dairy: | _____ | average # of servings per day |
| Meat: | _____ | average # of servings per day |
| Bread: | _____ | average # of servings per day |
| Sweets: | _____ | average # of servings per day |
| Snacks: | _____ | average # of servings per day |
| Water: | _____ | # of 8 oz. glasses per day |

Do you intermittent fast? ☐ No ☐ Yes _____ hrs.

## Caffeine

| | | | |
|---|---|---|---|
| Soda: | ☐ No ☐ Yes | _____ | # per day |
| Tea: | ☐ No ☐ Yes | _____ | # per day |
| Coffee: | ☐ No ☐ Yes | _____ | # per day |

## Alcohol

| | | | |
|---|---|---|---|
| Wine: | ☐ No ☐ Yes | _____ | # per day |
| Beer: | ☐ No ☐ Yes | _____ | # per day |
| Spirits: | ☐ No ☐ Yes | _____ | # per day |

## Smoking

| | | | |
|---|---|---|---|
| Cigarettes: | ☐ No ☐ Yes | _____ | # per day |
| Recreational Drugs: | ☐ No ☐ Yes | _____ | # per day |

## Exercise

Exercise: ☐ No ☐ Yes _____ times per week
Intensity: ☐ Light ☐ Moderate ☐ Vigorous
Type: ☐ Walk ☐ Jog ☐ Swim ☐ Weight Train ☐ Bike
☐ Yoga ☐ Cross Fit ☐ HIIT ☐ _____

## Sleep

Sleep quantity: _____ average hours per night
Sleep quality: ☐ Poor ☐ Fair ☐ Excellent
Snoring: ☐ No ☐ Yes
Sleep Apnea: ☐ No ☐ Yes Sleep study date _____

## Emotional Support and Stress

Level of emotional support: ☐ Little to none ☐ Some ☐ Alot
Level of stress / depression: ☐ Mild ☐ Moderate ☐ Severe

## Metabolic Balance

Comprehensive blood panel completed:
☐ Within past year ☐ Over one year ago ☐ Never

## Sexual History

*Women*
Date of Last Period: _____
Post Menopause: ☐ No ☐ Yes ☐ Unsure
Hysterectomy: ☐ No ☐ Yes If yes, date: _____
Hormone Replacement: ☐ No ☐ Yes If yes, HRT type: _____
Birth Control: ☐ None ☐ Birth Control Pills ☐ Tubal Ligation ☐ Vasectomy ☐ _____

Exams in the past 12 months:
Mammogram ☐ No ☐ Yes
OB/GYN ☐ No ☐ Yes
Bone Density ☐ No ☐ Yes

*Men*
Prostate Enlargement: ☐ No ☐ Yes ☐ Don't know
Elevated PSA: ☐ No ☐ Yes ☐ Don't know
Erectile Disfunction ☐ No ☐ Yes ☐ Don't know

## Bioidentical Hormone Replacement *(Complete this section **only if** you are being seen for Bioidentical Hormones or Lifestyle Medicine)*

I am sexually active. ☐ No ☐ Yes
I want to be sexually active. ☐ No ☐ Yes
I have completed my family. ☐ No ☐ Yes
I am able to achieve orgasm. ☐ No ☐ Yes
I currently use steroids for athletic purposes. ☐ No ☐ Yes

***The above information is accurate and complete to the best of my knowledge.***

**Patient Signature:** _____ **Date:** _____

## Office Use - Provider / RN Notes:

**Reviewed by:** _____ **Date:** _____
*Provider / RN Signature*