

Please bring this completed confidential **Registration Form** to your visit with Dr. Monash...

Name: First _____ Middle _____ Last _____

Address: _____

Telephone: (H) _____ (C) _____ (W) _____

Soc. Sec. # _____ Date of Birth _____ Age _____

Marital Status: Married Single Divorced Widowed Separated

Spouse/Partner's Name: _____

Occupation: _____ Employer's Name: _____

Employer's Phone #: _____ Address: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Advance Directive:	Do you have a living will?	Yes	No
	Healthcare Power of Attorney?	Yes	No

If yes, contact person and phone number for documentation: _____

Are you responsible for paying all financial obligations? Yes No

If no, please provide the following information for the responsible party:

Name: _____ Relation to you: _____ Phone #: _____

Primary Pharmacy: _____ Phone #: _____

Primary Care Physician/Referring Physician: _____ Phone #: _____

Insurance: Primary: _____ ID #: _____ Group #: _____

Name: _____

Past/Present Medical Problems: _____

Medication Allergies and Reactions: _____

Medications: _____

Dosages: _____

Previous Surgeries: _____

Date: _____

Have you ever been diagnosed with, or suffered from the following (please circle)?

Diabetes

Depression

High Blood Pressure

Leaking of Urine

High Cholesterol

Swollen Ankles

Sleep Apnea

Blood Clot

Reflux/Heartburn

Social Anxiety

Back Pain

Menstrual Irregularities

Joint Pain

Frequent Headaches

Do you smoke cigarettes? Yes No If yes, packs/per/day: _____ for: _____ years

Have you quit? If so, years smoked: _____ Quit date: _____

Do you drink alcohol? Yes No If yes, number of drinks/week: _____

Is your weight due to: Portion Control Sweet Cravings Both

Family History of significant medical problems:

Mother: _____

Father: _____

Siblings: _____

Children: _____

Please check any of the following that you have, or have had in the recent past:

Neurologic

- Dizziness
- Temporary vision loss
- Confusion
- Headache
- Paralysis
- Numbness in hands/feet
- Weakness
- Seizures

Hematologic, Immunologic

- Chills
- Fever
- Easy bruising
- Night sweats
- Fatigue
- Swollen lymph nodes

Gastrointestinal

- Difficulty swallowing
- Constipation
- Diarrhea
- Indigestion
- Nausea
- Abdominal pain
- Vomiting
- Blood in stool

Endocrinologic

- Excessive thirst
- Menopausal
- Hair loss
- Pregnancy

Otolaryngologic

- Nosebleeds/Bleeding gums
- Cataracts
- Nearsightedness
- Farsightedness
- Hard of hearing

Obstetric

- Pregnancies
- Live births

Respiratory

- Choking at night
- Shortness of breath
- Wheezing
- Productive cough (mucous/blood)
- Chronic cough

Cardiovascular

- Chest pain
- Irregular heartbeat
- Leg cramps with walking/exercise
- Blood clot
- Low blood pressure
- Swelling of feet/ankles

Genitourinary

- Frequent urination
- Painful urination
- Leaking of urine
- Blood in urine
- Difficulty emptying bladder

Psychiatric

- Anxiety
- Depression
- Unusual stress
- Bulimia
- Anorexia
- Bipolar
- Schizophrenia

Skin

- Itching
- Skin sores/ulcers
- Rashes/Discoloration

Musculoskeletal (Pain/Weakness)

- Shoulder
- Back
- Foot
- Hand
- Hip
- Knee
- Ankle
- Other

DIET	TIME LENGTH	YEAR	WEIGHT LOST
3-hour Diet			
Appetite Suppressant Gum			
Adkins Diet			
Beverly Hills Diet			
Bioslim			
Cabbage Soup Diet			
Caborad			
Carbohydrate Addicts Diet			
Dexatrim			
Diabetic Diet			
Diuretics			
Fit For Live			
Herbal Remedies			
Hospital Diet			
Jenny Craig			
Laxatives			
Low Carbohydrate Diet			
Low Fat Diet			
Medifast			
Meridia			
Metabolife			
Metabolite			
NutriSystem			
Optifast			
Overeater's Anonymous			
Perricone Promise			
Phen-Fen			
Phentermine			
Physician Supervised Diet			
Redux			
Richard Simmons Deal-A-Meal			
Slim Fast			
South Beach Diet			
Starvation Diet			
Sugar Busters			
The Diet Center			
The Grapefruit Diet			
The Pritikin Diet			
The Scarsdale Diet			
The Zone			
TOPS			
Trim Spa			
Weight Down Workshop			
Weight Loss Camp			
Weight Watchers			
Xenical			