JAY J GARCIA MD
WEIGHT LOSS & WELLNESS CENTERS

PATIENT INFORMATION
(please print)

FIRST NAME	LAST NAME	DATE

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	

STREET ADDRESS	CITY	STATE	ZIP

EMPLOYER	OCCUPATION

WORK PHONE	HOME PHONE
Can we leave a message at this number? ☐ Yes ☐ No	Can we leave a message at this number? ☐ Yes ☐ No

CELL PHONE	EMAIL ADDRESS
Can we leave a message at this number? ☐ Yes ☐ No	Can we email you appointment reminders? ☐ Yes ☐ No

EMERGENCY CONTACT NAME	PHONE NUMBER	PRIMARY PHYSICIAN NAME	PHONE NUMBER

HOW DID YOU HEAR ABOUT US?
☐ Current patient
☐ Referred by patient (please specify patient)
☐ Practice website
☐ Internet
☐ Other (please specify)

Payment will be collected for the first medication order prior to it being placed. After initial insertion, medication payments will be collected at the time of insertion. Please be advised that no refunds are given.

PATIENT SIGNATURE	DATE

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HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

(please print)

NAME	DATE	DOB	AGE

Medical history (questions 1-27). Please check the answer that applies to each question. Leave blank any questions you wish to discuss only with the doctor. Do you have a history of:		Does not apply	Myself	Siblings	Parents	Grand-parents
1.	Migraine headaches	☐	☐	☐	☐	☐
2.	Cancer	☐	☐	☐	☐	☐
3.	Diabetes	☐	☐	☐	☐	☐
4.	Heart Disease	☐	☐	☐	☐	☐
5.	Arthritis	☐	☐	☐	☐	☐
6.	Liver disease (hepatitis, cirrhosis?)	☐	☐	☐	☐	☐
7.	Psychiatric illness (depression, panic attacks, Schizophrenia?)	☐	☐	☐	☐	☐
8.	Autoimmune disease (Lupus, etc?)	☐	☐	☐	☐	☐
9.	Endocrine gland abnormalities (thyroid, etc?)	☐	☐	☐	☐	☐
10.	High blood pressure	☐	☐	☐	☐	☐
11.	Neurological disease (stroke, seizures, Parkinson's disease?)	☐	☐	☐	☐	☐
12.	Lung disease (asthma, emphysema?)	☐	☐	☐	☐	☐
13.	Kidney disease (stones, infections?)	☐	☐	☐	☐	☐
14.	Stomach disease (ulcers, etc?)	☐	☐	☐	☐	☐
15.	Bowel disease (malabsorption, lactose intolerance, diverticulitis, Crohn's disease?)	☐	☐	☐	☐	☐
16.	Endometriosis	☐	☐	☐	☐	☐
17.	Alcoholism, prescription or recreational drug abuse	☐	☐	☐	☐	☐
18.	Weight control problems	☐	☐	☐	☐	☐
19.	Osteoporosis	☐	☐	☐	☐	☐
20.	Carpal tunnel syndrome	☐	☐	☐	☐	☐
21.	Anemia	☐	☐	☐	☐	☐
22.	HIV/AIDS	☐	☐	☐	☐	☐

23. Please provide an explanation for any items for which you checked "myself":

24. Please list all surgeries you have had, including plastic surgery:

25. Please list all drug allergies:

26. Please list all medications that you are currently taking, including hormones and supplements

Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:
Name:	Dose:	Times/Day:

27. Are you currently receiving: Radiation therapy: ☐ Yes ☐ No Chemotherapy: ☐ Yes ☐ No

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(please print)

NAME	DATE

CURRENT STATUS (questions 1-9)

1.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
2.	Number of children:	Number living in your household:
3.	Occupation:	
4.	Alcohol consumption: drinks per week	
5.	Smoking: Currently smoke? ☐ Yes ☐ No Previously smoked? ☐ Yes ☐ No For years	What? How much per day? What? How much per day?
6.	Current recreational drug use: ☐ Yes ☐ No	What?
7.	Coffee/tea (caffeine):	8 oz. cups per day
8.	Diet soda or other drinks with aspartame:	8 oz. cups per day
9.	Water:	8 oz. cups per day

Are you currently experiencing the following symptoms to a degree you consider to be substantial or unusual? (questions 1-21)

1.	Headaches	☐ Yes	☐ No
2.	Visual problems	☐ Yes	☐ No
3.	Hearing loss	☐ Yes	☐ No
4.	Ringing in ears	☐ Yes	☐ No
5.	Sore throat	☐ Yes	☐ No
6.	Allergy symptoms (nasal congestion, watery eyes, post nasal drip)	☐ Yes	☐ No
7.	Loss of smell or taste	☐ Yes	☐ No
8.	Lumps in neck, armpits, groin or breast	☐ Yes	☐ No
9.	Chest pain	☐ Yes	☐ No
10.	Shortness of breath at rest	☐ Yes	☐ No
11.	Shortness of breath with exertion	☐ Yes	☐ No
12.	Palpitations	☐ Yes	☐ No
13.	Abdominal pain	☐ Yes	☐ No
14.	Diarrhea	☐ Yes	☐ No
15.	Constipation (hard or effortful bowel movements)	☐ Yes	☐ No
16.	Blood in stool or black stool	☐ Yes	☐ No
17.	Difficulty urinating	☐ Yes	☐ No
18.	Leaking urine	☐ Yes	☐ No
19.	Urinating at night If you answered yes, times per night	☐ Yes	☐ No
20.	Genital discharge or sores	☐ Yes	☐ No
21.	Muscle, bone or joint pain If you answered yes, please specify:	☐ Yes	☐ No

MALES ONLY (questions 1-8)

1.	Ejaculation causes pain	☐ Yes	☐ No
2.	Difficulty attaining/maintaining erection	☐ Yes	☐ No
3.	Premature ejaculation	☐ Yes	☐ No
4.	Infertile	☐ Yes	☐ No
5.	Low sperm count	☐ Yes	☐ No
6.	Underactive sex drive	☐ Yes	☐ No
7.	Overactive sex drive	☐ Yes	☐ No
8.	Date of last prostate exam		

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HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

(please print)

NAME	DATE

FEMALES ONLY (questions 1-10)

1.	Underactive sex drive	☐ Yes	☐ No
2.	Overactive sex drive	☐ Yes	☐ No
3.	Missed periods	☐ Yes	☐ No
4.	Pelvic soreness	☐ Yes	☐ No
5.	Menstrual pain	☐ Yes	☐ No
6.	Heavy menstrual bleeding	☐ Yes	☐ No
7.	Hot flashes	☐ Yes	☐ No
8.	Infertile	☐ Yes	☐ No
9.	Birth control If yes, what type? ☐ Pill ☐ IUD ☐ Sponge ☐ Diaphragm ☐ Foam ☐ Condom ☐ Other (specify)	☐ Yes	☐ No
10.	Date of last: Menstrual period Breast exam Pap smear Mammogram		

YOUR GOALS (questions 1-2)

1.	What are your most important expectations as a patient?	
2.	Date of last: Colonoscopy (or sigmoidoscopy): Rectal exam Stress EKG (treadmill stress test): Chest x-ray If any of the above tests abnormal, please describe:	

CURRENT EXERCISE SUMMARY (questions 1-4)

1.	How often do you engage in aerobic exercise (walking, jogging, biking and swimming)?	times per week
2.	Please describe your routine:	
3.	How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch and toning classes, brief stretching after aerobics or weights)?	times per week
4.	Please describe your routine:	

FITNESS ACTIVITY ASSESSMENT (questions 1-8)

1.	Are you currently involved in an exercise program?	☐ Yes	☐ No
2.	Have you ever been a member of a health club/gym? If yes, for how long?	☐ Yes	☐ No
3.	Are you currently a member of a health club/gym?	☐ Yes	☐ No
4.	Have you ever worked with a personal trainer? If yes, for how long? Do you enjoy working with a trainer?	☐ Yes ☐ Yes	☐ No ☐ No
5.	Are you currently working with a personal trainer?	☐ Yes	☐ No
6.	Do you have exercise equipment at home (bike, treadmill, free weights, etc.)?	☐ Yes	☐ No
7.	Are you currently receiving physical therapy? If yes, please describe:	☐ Yes	☐ No
8.	If exercise is not part of your weekly routine, please explain why: ☐ Lack of time ☐ No motivation ☐ Physical limitations ☐ Unsure what to do ☐ Don't enjoy it ☐ Other:	☐ Yes	☐ No

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HORMONE REPLACEMENT THERAPY QUESTIONNAIRE

(please print)

NAME	DATE

SUPPLEMENTATION			
1.	Are you taking vitamins, minerals or herbs on a routine? If yes, please list what you are taking:	☐ Yes	☐ No

	SYMPTOMS (questions 1-27). Check the box that best describes the following symptoms you might have:	Never	Mild/ Rare	Moderate/ Occasional	Severe/ Often
1.	Water retention	☐	☐	☐	☐
2.	Inflamed or bleeding gums	☐	☐	☐	☐
3.	Nosebleeds	☐	☐	☐	☐
4.	Indigestion after eating	☐	☐	☐	☐
5.	Flatulence (gas)	☐	☐	☐	☐
6.	Allergy or food sensitivities Please list:	☐	☐	☐	☐
7.	Lactose intolerance	☐	☐	☐	☐
8.	Dependency on antacids	☐	☐	☐	☐
9.	Toenail or fingernail fungus	☐	☐	☐	☐
10.	Boils or stys	☐	☐	☐	☐
11.	Vaginal yeast infections (women)	☐	☐	☐	☐
12.	Jock itch (men)	☐	☐	☐	☐
13.	Difficulty losing or gaining weight Please describe:	☐	☐	☐	☐
14.	Sleep problems	☐	☐	☐	☐
15.	Poor concentration	☐	☐	☐	☐
16.	Rapid mood swings	☐	☐	☐	☐
17.	Impatient, moody, nervous	☐	☐	☐	☐
18.	Lack of mental alertness	☐	☐	☐	☐
19.	Depression	☐	☐	☐	☐
20.	Dry hair, flaky scalp, and/or dry, brittle skin	☐	☐	☐	☐
21.	Acne	☐	☐	☐	☐
22.	Hair thinning or falling out	☐	☐	☐	☐
23.	Premenstrual tension (females only)	☐	☐	☐	☐
24.	Are there any other health issues that are causing you problems or that you would like to discuss?			☐ Yes	☐ No

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LIFESTYLE CHANGES SCALE

(please print)

NAME	DATE

Review the events below. Beside each one, indicate the number of times each event occurred during the past year only.

1.	Death of a spouse		22.	Change in responsibilities at work	
2.	Divorce		23.	Son or daughter leaving home	
3.	Marital separation		24.	Trouble with in-laws	
4.	Jail term		25.	Outstanding personal achievement	
5.	Death of a close family member		26.	Spouse begin or stop work	
6.	Personal injury or illness		27.	Begin or end school	
7.	Marriage		28.	Change in living conditions	
8.	Fired at work		29.	Revision of personal habits	
9.	Marital reconciliation		30.	Trouble with boss	
10.	Retirement		31.	Change in work hours or conditions	
11.	Change in health of family member		32.	Change in residence	
12.	Pregnancy		33.	Change in schools	
13.	Sex difficulties		34.	Change in recreation	
14.	Gain of a new family member		35.	Change in religious activities	
15.	Business readjustment		36.	Change in social activities	
16.	Change in financial state		37.	Change in sleeping habits	
17.	Death of a close friend		38.	Change in number of family get-togethers	
18.	Change to a different line of work		39.	Change in eating habits	
19.	Change in number of arguments with spouse/significant other		40.	Vacation	
20.	Mortgage over $100,000		41.	Religious holidays	
21.	Foreclosure of mortgage or loan		42.	Minor violations of the law	

PATIENT SIGNATURE	DATE

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PATIENT ACKNOWLEDGMENT OF OFFICE POLICIES

(please print)

Please initial each item

_____ I understand that I must cancel my appointment within 24 hours prior to my scheduled appointment if I am unable to make it to the office.

_____ I understand that failure to cancel my appointment within 24 hours prior to my scheduled appointment will result in the posting of a $35.00 cancellation fee to my account.

_____ I understand that all returned checks will be subject to any applicable bank fees, as well as any applicable collection legal fees.

_____ I understand that payment is due at the time services are rendered.

_____ I understand that services are not reimbursed by insurance and that the office does not provide or fill out claim forms for insurance purposes.

_____ I understand if my account is turned over to a collection agency for non-payment, I will be responsible for the collection agency fee as well.

My signature below and initials above indicate that I have read and understand and I agree to comply with all the above.

Signature of responsible party_____

Date_____

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Receipt of notice of privacy practices written acknowledgment form and authorization for the use of disclosure of individually identifiable health information to business associates of Jay J. Garcia, MD.

I, (patient name) _____ ,
have received a copy of Jay J. Garcia, MD's Notice of Privacy Practices.

Signature of patient _____ Date _____

Patient authorization for disclosure of protected health information

I, _____ D.O.B. _____ ,
SS# _____, authorize Dr. Garcia and/or staff to release information to the following individuals regarding my appointment and account history, and hereby authorize these individuals to reschedule, verify, make cancellation, and tender payment on my behalf.

Name _____

Name _____

Name _____

Name _____

Signature _____ Date _____

Witness _____ Date _____