**Manuel Lam, MD**

**845 Oak Grove Suite 110**

**Menlo Park, CA 94025**

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| **Patient Information** Please Print All Information Clearly With Pen | |
| Title |  Mr.  Mrs.  Miss  Ms.  Dr. |
| First, Middle, Last Name |  |
| Preferred / Nickname |  |
| Address |  |
| City, State, Zip Code |  |
| Preferred Phone Number(s) |  |
| Okay to leave a message on phone? |  |
| E-mail address |  |
| Birthday (mm/dd/yyyy) |  |
| Your Occupation and Employer Name |  |
| Marital Status (& spouse name) |  |
| Spouse's Occupation and Employer Name |  |
| Primary Care Provider |  |
| Names of Other Specialists |  |
| How did you hear about us? |  |
| Who referred you to my practice? |  |

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| **Pharmacy Information** | |
| Pharmacy Name |  |
| Pharmacy Phone Number |  |
| Pharmacy Street Address (or street name) |  |
| Pharmacy City / Town |  |
| **Emergency Contact Information** | |
| First and Last Name and Relationship |  |
| Phone Number(s) |  |
| **Authorization to Release Healthcare Information** | |
| Please list below the people that you authorize us to discuss your healthcare and health conditions with? (optional) | |
| Name, Relationship, and Phone # |  |
| Name, Relationship, and Phone # |  |
| Name, Relationship, and Phone # |  |

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| **List All Prescriptions and Non-Prescription Medications**  This includes vitamins, herbs, supplements, inhalers, over the counter pain pills (Advil, Aleve, Tylenol, etc.)  check here for "no meds" | | |
| Medication | Dose (e.g. mg/pill) | How many times per day? |
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| **Allergies to Medications (list drug name and allergic reaction below)** | | |
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| **Medical Conditions and Surgeries** | |
| **Do have a history of any of the following conditions?**   High Blood Pressure   High Cholesterol   Diabetes   Coronary artery disease   Previous heart attack or stent?   Previous heart surgery (bypass?)   Congestive heart failure   Stroke / TIA   Arrhythmias   Asthma / Emphysema / COPD   Obstructive Sleep Apnea   Kidney disease   PCOS (polycystic ovary syndrome)   Blood clots   Low Thyroid (Hypothyroidism)   Parkinson’s or Alzheimer’s   Depression or Anxiety   Cancer, type: | **List any OTHER MEDICAL CONDITIONS below:** |
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| **List any previous SURGERIES below:** |
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| **Social History** | |
| **Marital Status** |  Single  Married  Partnered  Divorced  Widowed |
| **Children's Names & Ages** |  |
| **Smoking History** |  I have never smoked  I previously smoked but quit   I currently smoke the following # of packs per day: |
| **Alcohol Use** |  I do not drink any alcohol.   I previously drank but quit. History of alcoholism?   I currently drink alcohol. How many drinks per week? |
| **Drugs / Illicit Substances** | Have you ever used recreational drugs?  **no**  **yes**  Are you currently using any street/illicit drugs? **no**  **yes** |
| **Sexual / Reproductive History** | Are you sexually active?  **no**  **yes**  If yes, are you trying to become pregnant?  **no**  **yes**  If not trying to conceive, what contraceptive method?  Is it possible that you are pregnant right now?  **no**  **yes**  Do you have a history of infertility?  **no**  **yes**  When was your last menstrual cycle?  How many menstrual cycles do you have per year? |

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| **Family History (list family members below with each of the following conditions)** | |
| **Indicate who in your family have any of the following medical conditions:**  (e.g. mother, father, brother, sister, children, cousins, uncles, aunts, grandparents) | Cancer (list types): |
| Diabetes: |
| Heart Disease: |
| High Blood Pressure: |
| High Cholesterol: |
| Hypothyroidism/Low Thyroid: |
| Sudden Death (age < 40): |
| Other Family Conditions: |
| **Review of Systems (please circle if you have any of the following)** | |
| **General** Fatigue Always Cold Always Hot | |
| **Heart** Chest Pain Palpitations Leg Swelling | |
| **Lungs** Shortness of Breath Coughing Wheezing | |
| **Abdomen** Nausea / Vomiting Constipation Diarrhea | |
| **Menstrual** Irregular Cycles No Menstrual Cycles Post-Menopausal | |
| **Mental Health** Depression Anxiety Trouble Sleeping | |
| **Skin** Hair Loss Acne Extra Facial Hair | |
| **Neurological** Headaches Numbness/Tingling Tremors | |

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| **Weight History** | | | |
| Current Weight | Lowest Weight?  Year? | Highest Weight?  Year? | Goal Weight |
| How much weight have you gained over following time periods?  6 mos 1 year 2 years 5 years | | | |
| What is the main reason why you are seeking to lose weight? | | | |
| When did you start gaining extra weight? | | | |
| What do you think are the main causes of your weight gain? | | | |
| List previous weight loss programs or diets or prescription medications for weight loss you have attempted (include names, dates and results): | | | |
| What do you think is the most effective way for you to lose weight? | | | |
| What do you think is your biggest obstacle to losing weight? | | | |
| Have you previously had or do you plan on having bariatric surgery? | | | |

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| **Diet and Nutrition Questionnaire (List common foods you eat at the following times of the day)** | | |
| **Meal** | **Main Dishes Side dishes Desserts Drinks** | **Eating Out / Restaurants** |
| **Breakfast** |  | #breakfasts out/week where? |
| **Morning Snacks** |  |  |
| **Lunch** |  | #lunches out/week where? |
| **Afternoon Snacks** |  |  |
| **Dinner** |  | # dinners out/week  where? |
| **Evening Snacks** |  |  |
| Do you frequently eat overnight? | | |
| Do you consider yourself a stress eater? | | |
| Do you feel hungry all the time? | | |
| Do you follow a special diet? | | |
| Are you able to participate in group sessions where you discuss eating habits with others in your group? | | |

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| **Activity and Exercise** |
| Please select your current activity level   Inactive – no regular physical activity with a sit down sedentary job   Moderate Activity – i.e. occasionally walk, jog, run, bike, golf, tennis   Heavy Activity – regular exercise at least 3x per week   Vigorous Activity – extensive exercise > 60 mins at least 4x/week |
| Please describe what physical activity or exercise you do and how often: |
| Do you do any form of resistance training and if so describe and how often (i.e. lift weights, resistance bands)? |
| What limits or prevents you from participating in more physical activity or exercise (e.g. arthritis, time)? |
| Do you have membership at any gyms or exercise facilities? Which one(s)? |
| Please list your interests, hobbies, group involvement, volunteer work, and/or travel: |

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| **Behavior Styles and Stress** |
| Behavior Style (select only one of the options)   I am calm and easygoing.   I am sometimes calm but frequently impatient.   I am seldom calm and have overwhelming drive for ambition.   I am hard driving and can never relax. |
| Please circle your **STRESS** level:  **0 1 2 3 4 5 6 7 8 9 10**  0=no stress 5=moderate stress 10=extreme stress |
| Have you or any family members ever been hurt, insulted, threatened or screamed at? |
| Please describe major sources of stress in your life and how they affect you: |

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| **Sleep Hygiene and Sleep Patterns** |
| What time do you usually go to sleep? |
| What time do you usually wake up? |
| Do you wake up throughout the night? |
| Do you wake up and eat overnight? |
|  I usually sleep 8 or more hours per night   I usually sleep 6 - 8 hours per night   I usually sleep 4 - 6 hours per night   I usually sleep < 4 hours per night |
|  I snore heavily at night   I wake up in the morning still tired.   Have you ever had a sleep study? **no yes**   I have sleep apnea; if yes do you use CPAP? no yes   I work and live a night schedule and sleep during the day |

**Thank you for taking the time to complete this form!**