

110 Hospital Road, Suite 101 Prince Frederick, MD 20678

1036 St. Nicholas Drive Waldorf, MD 20603

Office: 410.535.8195

CalvertHealthMedicalGroup.org

Contact Information:

Patient Name: Patient Address: Patient Telephone: Patient Email:	()	Date o	f Birth:
PCP: Address:			
Telephone:	()		
Behavioral Health Prov Address: Telephone Number:	ider:		
Referring Provider:			
•	•	esity/ Anti-obesity medications ge for dietitian?	
Demographics: Height: Highest Adult Weight: Lowest Adult Weight: Past Medical History	orv:		
			2/2
Cardiovascular Hypertension Chest Pain Heart Attack/ CAD Palpitations/Arrhyt Pacemaker/AIDC Heart Valve Disease Coronary Stent Poor Exercise Toler Peripheral Vascular	hmias [Pulmonary Asthma COPD Cough Shortness of Breath Sleep Apnea Wheezing Bronchitis Tuberculosis Obesity Ulcers	GI/Endocrine Hernia Heartburn Hepatitis Liver Disease Hyperthyroidism Hypothyroidism Pre-Diabetes Diabetes Type I Type II High Cholesterol Thyroid Cancer



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Neuromuscular	Hematologic	Miscellaneous CalvertHealthMedicalGroup.org
☐ TIA or Stroke	Anemia	☐ Cataracts
Seizures	Sickle Cell	Drug Dependency
Cerebrovascular Disease	Bleeding Disorder	Glaucoma
☐ Dementia	☐ Chemotherapy	Prostate Problems
Osteoarthritis	☐ HIV/AIDS	☐ Glasses/Contacts
Rheumatoid Arthritis	Factor V	Psychiatric Disorder
Neuromuscular Disease		Anxiety
		Depression
		Cancer type:_
		Other Conditions:
Allergies (Drug/Food):		
Past Surgical History:		
Type of Surgery		Date

Current Medications, Vitamins, Herbs, or Supplements:

Medication	Amount	Frequency	Prescriber& Since(year)



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Family History:	CalvertHealthMedicalGroup.org
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Mother ☐ Diabetes Type I☐ Heart Disease ☐ Thyroid Cancer ☐ Hypertension ☐ High Cholesterol
☐ Diabetes Type II
Father Diabetes Type I Heart Disease Thyroid Cancer Hypertension High Cholesterol
☐ Diabetes Type II
Social History:
Tobacco
Have you ever smoked? Yes No If yes, what do you (did you) smoke?
Are you still smoking? Yes No If yes, how many years? Alcohol
Do you drink alcohol, including beer, wine or hard liquor? Yes No
If yes: Daily Almost Daily 1-3 times per week Less than one time per week
Do you drink caffeine? Yes No If yes, how many cups per day?



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Program	Describe/Year	Months on Program	Pounds Lost	Comments
Diet Pills (Any)				
Weight Watchers				
Liquid Diets (
Optifast or Slim Fast, etc.)				
Low Calorie diets				
Low Carb diets or Atkins				
Jenny Craig or Nutri-System				
Fad Diets				
Physician Monitored Diet "Diet Clinics"				
Hypnosis/Counseling				
Surgery				
Dietician Counseling				
OA				
Gym Membership/ Exercise Plans				

What diet/weight loss plan has worked the best? What do you feel has been your biggest barrier to losing weight/exercising?