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Phone # 810-216-1809
Fax: 810-216-1263

Lake Huron
Medical Center

Fax

To:		**From:**	Maegan Stewart ~ Exercise Physiologist
Fax:		**Pages:**	
Phone:		**Date**	
Re: Wellness		**cc:**	

☐ Urgent **x For Review** ☐ Please Comment **x Please Reply** ☐ Please Recycle

RE: Patient Inquiry to Wellness Program—Referral

Please have your primary care provider send us the following:

1. Copy of most recent office visit including: medical, social, surgical history)
2. Active medication list with dose and time of day taken
3. Recent labs, if any within the last 6 months
4. * A Referral and insurance authorization will be needed for:
   Carriers of either Keenan or BlueCare Network Insurance.

   Notes:
   ____
   ____
   ____
   ____

Please Return Fax: **ATTN: Wellness Program**
Fax # 810-216-1263

This message is intended only for the use of the individual or entity to which it is addressed and may contain information that is CONFIDENTIAL. If the message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this is strictly prohibited. IF you have received this communication in error, please notify us immediately by telephone and return the original message to us at the above address. Thank you.

Lake Huron Medical Group

Primary Care Physician:____ Phone #_______________________

Patient Information

Last Name:______________________________ First Name:______________________________ M.I__________

Previous Last Name:________________________________

Date Of Birth:____________________ Sex: M____ F____ T _____ Social Security #________________________

Address:___________________________________ City:_________________________ State:______ Zip:_______

Cell Phone #____________________ Home Phone #______________________ Work #______________________

Can We Text Your Number? Yes_____No_____ Phone # to text: ____

E-Mail Address:____

Race: Caucasian______ African American______ Hispanic______ Other (List) ______________________________

Language: English______ Spanish________ Other_______________

Marital Status: Married______ Single_______ Partner_______ Other______________

Pharmacy:____

Insurance Information

Primary Insurance Company:____

Name of Insured:_________________________ Date Of Birth:________________ Sex: M_____F______T____

Other Insurance:____

Name of Insured:_________________________ Date of Birth:__________________ Sex: M_____F_____T_____

Yes____ No_____ May we leave messages, which may include but not limited to, information about prescriptions or test results on you answering machine?

Yes____ No_____ May we leave messages, which may include but are not limited to, information about prescriptions or test results with members of your household? If Yes Please list the names:____

Emergency Contact Person or Nearest Relative

Last Name:________________________________, First Name:____________________________

Relationship (If any)_________________________, Phone # ______________________________

Signature:____ **Date:**___________________________

Lake Huron Medical Center

WELLNESS-WEIGHTLOSS ENROLLMENT FORM

Name: ___________________________________DOB: ________________

How did you hear about the program?

____

Daily life activity: (circle one answer)
Sitting most of the day
I walk or stand most of the day
I lift heavy machinery or move frequently all day

Goal weight you'd like to lose: _______

CURRENT FOOD INTAKE

How many meals do you eat in a day?

____

What is your main meal of the day?

____

What do you eat at these meals?

List examples of what you normally eat

Breakfast: @ time: _______am/pm

____
____
____

Lunch: @ time: _______am/pm

____
____
____

Dinner: @ time: _______am/pm

____
____
____

Snacks: @ time: _______am/pm

____
____

How much water do you drink in a day?

__ None__ 1-2 glasses __ 3-4 glasses __6 or more

How much caffeine do you drink daily?______

How often do you eat out?
~ Fast food/restaurants/drive thru/take out?
___________________ days/week

EXERCISE REVIEW

Do you currently exercising regularly?
yes or no

Do you take part in any aerobic exercise?
yes or no -walking, biking

Do you participate in strength training?
yes or no -lifting weights

PT HEALTH HISTORY

Currently or past treatment for:

Type 1 or 2 Diabetes: *yes or no*
Pre Diabetes: *yes or no*
Hypertension: *yes or no*
High Cholesterol levels: *yes or no*
* *(LDL, HDL, Total Cholesterol): circle*
High Triglycerides: *yes or no*
Fatty/Abnormal Liver: *yes or no*
Sleep Apnea (snoring): *yes or no*
Heartburn (GERD) Reflux: *yes or no*
Polycystic Ovarian Syndrome: *yes or no*
Hyper/hypothyroidism: *yes or no*
Myalgia / Muscle aches: *yes or no*
Arthritis: *yes or no*
Swelling /edema: *yes or no*
Fatigue: *yes or no*
Depression/anxiety: *yes or no*
Date of last Bone Density: *yes or no*
Do you have a Pacemaker: *yes or no*

OTHER HEALTH CONCERNS:

____
____

EX) Pain, stress, physical limitations to exercise, migraine, constipation, breathing issues, allergies to foods

~ Please fill out this form as completely as possible & bring with you to your appointment ~