IOANA A. Bina, MD, PhD

1400 Oak Avenue, Saint Helena , Ca. 94574.
Tel: 707-963-3322
email: office@drbinanapavalley.com

New Patient Paperwork

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Ioana A Bina, MD to release my personal medical information to me.

Patient's Signature:_____ Date: _____

Name:				Date:
Address:			Country:	
City:		State:		Zip/Postal Code:
Home Phone:		Work Phone:		Fax:
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office:_____Email_____Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:				Referred by:
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

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Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Weight_____ **Height**_____ **Blood Pressure** (if known)_____ **% Body Fat** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
Please list (attach sheet if necessary)

_____

2. In the past, have you used birth control pills and/or antibiotics? _____

a. For how long? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (Circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average?_____

6. Do you have any food allergies, sensitivities or restrictions?_____

_____

7. Do you smoke, drink alcohol or use recreational drugs?_____

a. How much, how often?_____

b. How often do you drink caffeinated beverages?_____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):_____

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9. Are there foods that you eat on a daily basis, almost daily basis?

a. Do you "miss" these foods if you do not eat them?

10. If applicable write briefly about your weight gain/loss history:

a. What do you feel triggered your weight fluctuation? (circle) heredity stress eating habits boredom

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity:

12. What methods have you tried to lose/gain weight

13. How is your energy level?

a. Are there times in the day that you feel best? worst?

14. Are you happy in your life right now?

15. What are your main sources of stress

16. How do you deal with your stress?

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes_____No_____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes_____No _____

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c. I get tired and/or hungry in the mid-afternoon. Yes_____No_____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert. Yes_____No _____

e. Now and then I think I am a secret eater. Yes_____No_____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes_____No_____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes_____No_____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes_____No_____

i. I feel shaky if I don't eat on time or if I don't snack. Yes_____No_____

j. I often find myself irritable or angry. Yes_____No_____

18. Check off any of the following that have applied to you within the last 30 days:

_____Do you feel nauseous?	_____Do you have abdominal/intestinal pain?
_____Do you have bloating?	_____Do you get bloated after meals?
_____Do you get heartburn?	_____Do you have diarrhea?
_____Do you have constipation?	_____Do you travel outside of the U.S.?
_____Do you have gas?	_____Are your stools compact/hard to pass?
_____Do you belch following meals?	_____Do you have gurgles in your stomach?
_____Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit_____ Below average_____ Average _____ Above average_____ Very fit_____

25. How often do you exercise? _____

a. What is your regimen? _____

_____

_____

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past? _____

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27. What are your fitness goals? (Circle all that apply)

General fitness endurance_____	Muscle toning _____
Weight loss/maintain weight _____	Muscle strengthening _____
Osteoporosis prevention _____	Muscular coordination/balance _____
Specific sport enhancement _____	Other_____
Flexibility_____	

28. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:			**Do you often:**		
Now	Past	Satisfactory	Now	Past	Feel depressed
Now	Past	Boring	Now	Past	Have anxiety
Now	Past	Demanding	**Do you often:**		
Now	Past	Unsatisfactory	Now	Past	Have irrational fears
Do you worry over:			Now	Past	Feel upset
Now	Past	Home life	Now	Past	Feel things go wrong
Now	Past	Marriage	Now	Past	Feel shy
Now	Past	Children	Now	Past	Cry
Now	Past	Job	Now	Past	Feel inferior
Now	Past	Income	**Have you:**		
Now	Past	Money problems	Now	Past	Seriously considered suicide
			Now	Past	Attempted suicide

29. Hospitalizations: _____

30. Briefly describe where you have lived since childhood: _____

_____

_____

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Surgeries, starting with most recent: _____

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Conclusion

Is there anything else you would like me to know about your health or any other concerns you might have?

What do you think needs to happen for you to feel better and what statement describes your approach to healt?
Please reiterate your goals for this visit: