

Patient Medical History Form

Name: (First) _____ (Last) _____ (MI) _____

Name you prefer to be called: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Preferred method of contact: Email Home Phone Cell Phone Work Phone

Spouse: _____ Number: _____

Primary Care Physician (name & number): _____

Preferred Pharmacy: _____

How did you hear about us? _____

Medical Information:

Are you now or have you ever been treated for any of the following?

	<u>Yes</u>	<u>No</u>
Depression	_____	_____
Diabetes	_____	_____
Glaucoma	_____	_____
Heart Disease	_____	_____
Heart Palpitations	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Lung Disease(asthma)	_____	_____
Sleep Disorder	_____	_____
Thyroid Disorder	_____	_____

PLEASE LIST ALL CURRENT MEDICATIONS,
VITAMINS & SUPPLEMENTS WITH DOSAGES:

Other Medical Problems: _____

Any Medication Allergies? Yes No List with reaction: _____

List all major surgeries (include the year): _____

Patient Medical History Form

Are you pregnant? Yes No Number of Children: _____ Do you need a child proof container? Yes No
 Current Method of Contraception: _____ LMP: _____ Is your menses regular? Yes No

Family History:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Rhythm | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Sudden Death | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Other Cancer (what kind): _____ | | <input type="checkbox"/> Other: _____ | |

Review of Symptoms:

Have you noted any physical symptoms in the last few days that may affect you starting on an aggressive weight reduction program (i.e. chest pain, palpitations, trouble breathing, insomnia, diarrhea, or vomiting)?

Yes No If yes, what symptoms? _____

List other providers you see regularly: _____

Social History:

Do you use any tobacco/nicotine products? Yes No How much/how often? _____

Do you drink alcohol? Yes No How much? _____ Daily Weekly Monthly

Have you ever been treated for alcohol or other substance abuse/dependence? Yes No

Who lives in your house? _____

Nutrition:

Do you plan meals? Yes No Who plans your meals? _____ Who does the shopping? _____

How often do you eat out? _____ How often do you eat "fast food"? _____

What restaurants do you go to most often? _____

Food cravings: _____

Worst food habits: _____

Snacking habits: _____

Do you drink Coffee/Tea? Yes No How much daily (8 oz = 1 cup)? _____

Do you drink Soda? Yes No How much daily (8 oz = 1 cup)? _____

Do you wake up hungry in the middle of the night? Yes No

What do you do? _____

Any history of binge eating? Yes No What type of food? _____

Do you eat nutritiously? Yes No Excessively? Yes No Excessively at night? Yes No

Do you count calories? Yes No

Patient Medical History Form

Exercise:

Do you exercise regularly? Yes No What type? _____

Times per week: _____ How long is each session: _____ Intensity: _____

Any problems with exercise? Yes No What problems? _____

Weight Loss History:

Goal Weight: _____ Age last at that weight? _____ Max Weight (not pregnant) _____ Height: _____

Any previous prescription weight loss medications? Yes No Please List: _____

Have you been overweight all your life? Yes No If no, how long? _____

Weight loss programs you have tried: _____

Graph your weight path over time (Please put a sketch of your weight highs and lows)

400
350
300
250
200
150
100
50
Childhood 20's 30's 40's 50's 60's 70's

Lifestyle:

Do you have a support team (spouse, children, friends, etc.)? Yes No

What are your reasons for losing weight (check all that apply):

Self-esteem Appearance General health

Physician recommendation Clothes don't fit Future event

Other: _____

What rewards have you considered giving yourself for this lost weight? _____

Health goals & improvements you wish to make: _____

Patient Medical History Form

DIET READINESS TEST

Answer the questions below to see how well your attitudes equip you for a weight-loss program. For each question, circle the answer that best describes your attitude

Section 1: Goals and Attitudes

1. Compared to previous attempts, how motivated to lose weight are you this time?

Not at all	Slightly	Somewhat	Quite	Extremely Motivated
1	2	3	4	5

2. How certain are you that you will stay committed to a weight loss program for the time it will take you to reach your goal?

Not at all	Slightly	Somewhat	Quite	Extremely Certain
1	2	3	4	5

3. Consider all outside factors now in your life (the stress you're feeling at work, your family obligations, etc.). To what extent can you tolerate the effort required to stick to a diet?

Cannot Tolerate	Can tolerate Somewhat	Uncertain	Can tolerate well Well	Can tolerate Easily
1	2	3	4	5

4. Think honestly about how much weight you hope to lose and how quickly you hope to lose it. Figuring a weight loss of 1 to 2 pounds per week, how realistic is your expectation?

Unrealistic	Somewhat unrealistic	Moderately unrealistic	Somewhat realistic	Very realistic
1	2	3	4	5

5. While dieting, do you fantasize about eating a lot of your favorite foods?

Always	Frequently	Occasionally	Rarely	Never
1	2	3	4	5

6. While dieting, do you feel deprived, angry and/or upset?

Always	Frequently	Occasionally	Rarely	Never
1	2	3	4	5

TOTAL Score: _____