GMOS Gainesville Medical Obesity Specialty Clinic

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 (check all that apply):

☐ Email ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Text Message: _____

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?

	Yes	No
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): _____

_____

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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:

☐ Breast Cancer	☐ Colon Cancer	☐ Diabetes	☐ Gallstones
☐ Heart Attack	☐ Heart Rhythm	☐ Hypertension	☐ Kidney Stones
☐ Stroke	☐ Sudden Death	☐ Thyroid Disease	☐ Obesity

☐ Other Cancer (what kind): _____ ☐ 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

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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: _____

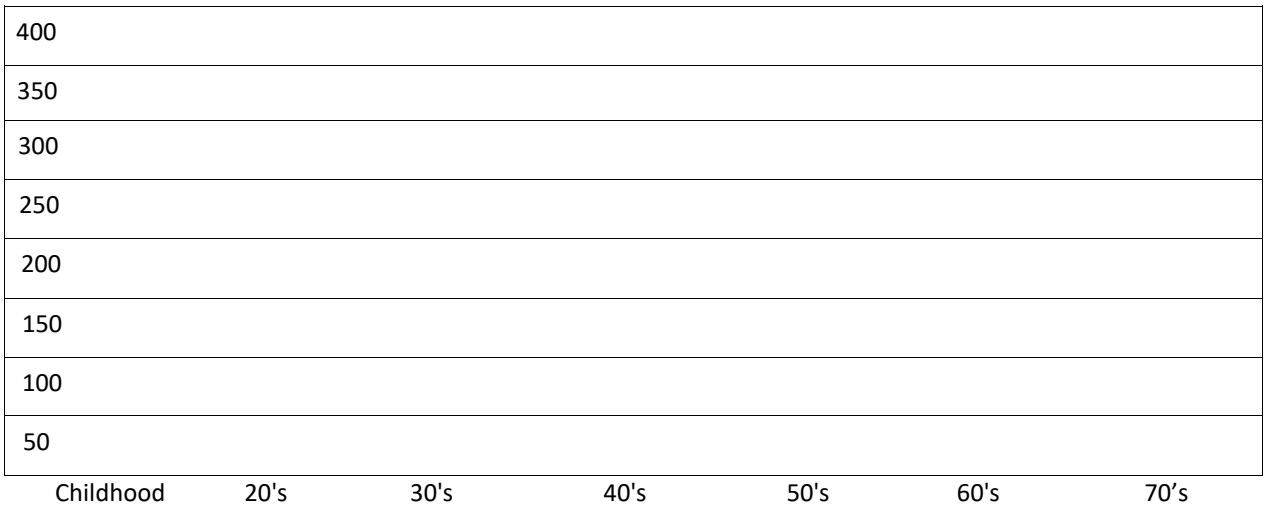
Any previous prescription weight loss medications? ☐ Yes ☐ No Please List: _____

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)



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

List your main 3 or 4 Motivating Reasons to lose weight.

☐ Appearance

☐ Clothes don't fit

☐ Self-esteem

☐ Physician recommendation

☐ Health Fears_____

☐ Future event_____

Other:_____

_____