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: _____

Spouse:_____Number:_____

Primary Care Physician (name & number): _____

Preferred Pharmacy: _____

How did you hear about us? _____

Preferred method of contact for appointment Reminders

☐ Phone Call (Home/Cell/Work) ☐ Email ☐ Text Message

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?

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:

How comfortable are you with meal planning? Cooking? _____

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

What restaurants do you go to most often?

Food cravings:

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)? _____

How often do you wake up hungry in the night, and need to eat to get back to sleep.?

Any history of sense of inability to control your eating?

Do you have trouble: Getting full? Getting hungry soon after a meal?_____

Do you have a strong drive/urge/craving to eat frequent small or snack meals? _____

Do you ever eat to soothe emotional, stress, fatigue, boredom, or as reward?_____

Exercise:

Do you exercise regularly? ☐ Yes ☐ No

Which physical activities/exercises do you enjoy doing?

What barriers to exercise do you have? _____

Weight Loss History:

Your lowest weight as an adult was? Age at that weight?_____ Max Weight (not pregnant) _____

Prior weight loss programs you have attended/used

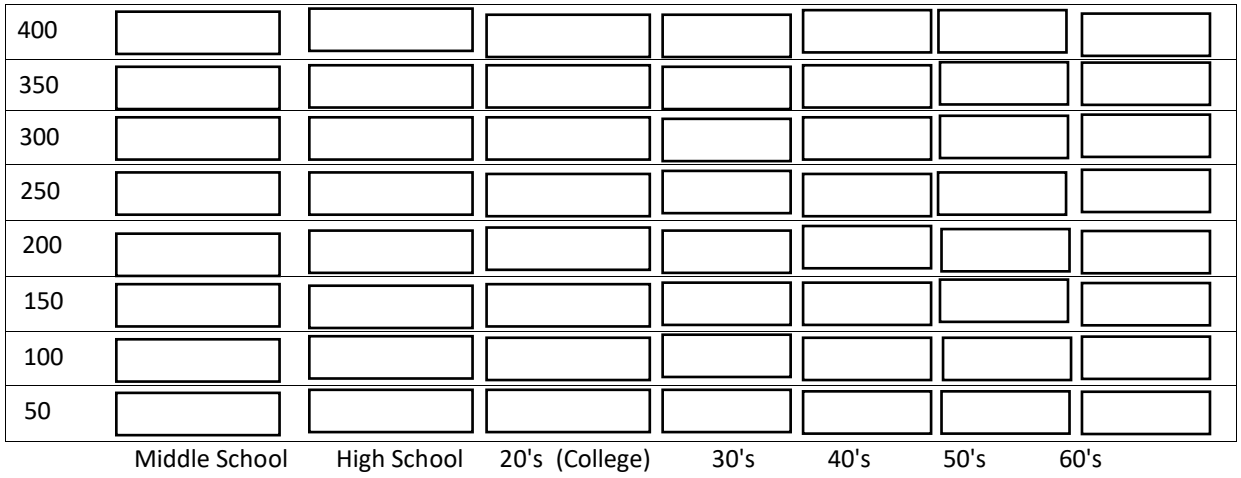
Prescription weight loss medications you have taken. Please List: _____

What about the above programs did you like the best? _____

As a child were you overweight?

Did you gain excessive weight after a traumatic event/illness/medication change or pregnancy? _____

Please help us by doing a basic graph of your weight over your life



What is your main concern as you start here as a new patient? _____

A new medication has been approved that is highly effective. Would you be comfortable with giving yourself a daily injection? _____ Once a week injection? _____