Patient Medical History Form

Name: (First)______________________________(Last)________________________________(MI)______

Name you prefer to be called:________________________________DOB:___________________________

Address: ____

City: ____ State: ____________ Zip: ________________

Email:____________________________________Social Security Number: Give to staff on first visit

Home Phone:_______________________________Cell Phone:____________________________________

Occupation:_____________________________________ Work Phone: ___________________________

Spouse:____Number:________________________________

Primary Care Physician (name & number): ____

Pharmacy (name & number): ____

How did you hear about us? ____

Preferred method of contact for appointment Reminders

☐ Email OR ☐ Text Message OR ☐ Phone Call (phone#_________________)

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:

____

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____

Other Medical Problems: ____

____

Any Medication Allergies? ☐ Yes ☐ No List with reaction: ____

____

List all major surgeries (include the year): ____

____

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Number of Children:__________Current Method of Contraception:___________LMP:__________

Is your menses regular? ☐ Yes ☐ No Do you have PCOS ☐ Yes ☐ No ☐ Not sure

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

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.?________________

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: ____

____

Which programs did you like the best? ____

As a child, were you overweight?______________________________(if so starting at what age)__________________

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

400
350
300
250
200
150
100
50

Middle School High School 20's (College) 30's 40's 50's 60's

Do you have a specific concern, you would like us to discuss? ____