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:

____

____

____

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____

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____

Other Medical Problems: ____

____

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

____

List all major surgeries (include the year): ____

____

Form developed from various sources including Medical Bariatrics of America, Novo Nordisk patient preparation form and others.

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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"? ____________________

Food cravings: ____

Snacking habits:____

How many sweetened drinks—soda, fruit juice, sweet tea, etc, do you drink per week?

Do you ever feel like your eating patterns can get out of control? ☐ Yes ☐ No

Do you eat between meals? ☐ Yes ☐ No if so what are your food choices?___________________________

Do you eat as a response to your emotions? ☐ Yes ☐ No

Do you have any dietary restrictions? ☐ Yes ☐ No

What kind of foods do you eat? ____

Is hunger a big issue for you? ☐ Yes ☐ No

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Exercise:

How many times a week do you take part in physical activity? ___________Length of sessions? ___________________

Which physical activities/exercises is the above and what activities do you enjoy? ______________________________

Weight Loss History:

Your highest (nonpregnant) weight as an adult was? ________________

What is *your* weight/obesity-management goals?

Short-term____

Long-term____

How many serious weight-loss attempts have you made in the past 5 years? 0 _____ 1______ 2______ 3______ 4+_______

Did you participate in any structured weight-loss programs in the past and, if so, which ones?__________________________

____

Was there one program that seemed to work best for you?____

What are some barriers that have kept you from losing weight and maintaining weight loss in the past? (e.g. Nutritional choices, no time for exercise, health issues)____

____

Have you ever been on an anti-obesity or weight-loss medication in the past or are you currently on one? (either over the counter or prescribed)____

If so which one(s)____

Current anti-obesity/weight-loss medications:____

As a child were you overweight?_____________________________Do you feel you were bullied or shamed for your weight? ☐ Yes ☐ No

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