Patient Medical History Form

Name: ____

DOB: ________________ Sex: ☐ M ☐ F

Street Address: ____

City: ___________________________ State: ___________________ Zip: ___________

Home Phone: _______________________ Work Phone: _________________________

Cell Phone: _______________________ Email: ___________________________

Emergency Contact: ________________________ Phone: _______________________

Primary Care Physician: ______________________ Phone: _______________________

How did you hear about us? ____

For Office Use Only:

Date: ________________

Chart # ________________

Goal Weight: ______________

Start Weight ______________

Chest: ________________

Waist: ________________

Hip: ________________

Waist/Hip Ratio: ___________

Reviewed by: __________

Present Status:

Are you in good health at the present time to the best of your knowledge? ☐ Yes ☐ No

Explain a "no" answer: ____

____

Are you under a doctor's care at the present time? ☐ Yes ☐ No

If yes, for what? ____

Do you have a Pacemaker_________ Neurostimulator__________ Any other medical implanted device__________

Prescription Drugs: List all

Drug:	Dosage:

Over-the-Counter medications, vitamins, supplements: List all

Product:	Dosage:

Any allergies to any medications? Foods? ☐ Yes ☐ No

Please list: ____

____

History of High Blood Pressure? ☐ Yes ☐ No

History of Diabetes? ☐ Yes ☐ No At what age: ________

History of Heart Attack or Chest Pain or other heart condition? ☐ Yes ☐ No

History of Swelling Feet? ☐ Yes ☐ No

History of Frequent Headaches? ☐ Yes ☐ No

Migraines? ☐ Yes ☐ No Medications for Headaches: ______________________________

History of Constipation (difficulty in bowel movements)? ☐ Yes ☐ No

History of Glaucoma? ☐ Yes ☐ No

History of Sleep Apnea? ☐ Yes ☐ No

If "yes", do you wear your CPAP? ☐ Yes ☐ No

Gynecologic History:

Pregnancies

Number: __________ Dates: ______________________________

Natural Delivery or C-Section (specify): ______________________________

Menstrual: ______________

Onset: ______________

Duration: ______________

Are they regular: ☐ Yes ☐ No

Pain associated: ☐ Yes ☐ No

Last menstrual period: ______________

Birth Control Method: ______________

Any Surgery: ☐ Yes ☐ No

Specify: (List all)	Date
______________	______________
______________	______________
______________	______________
______________	______________
______________	______________

Family History: (please note if anyone had a sudden death under 45 years old)

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Review of Systems: (Check all that apply)

General: ☐ Fatigue ☐ Night Sweats ☐ Unexplained weight change

Eyes: ☐ Visual trouble ☐ Trouble with eye pressure ☐ Eye redness/discharge

Ears: ☐ Difficulty hearing ☐ Ringing in ears

Nose: ☐ Chronic discharge/drainage

Throat: ☐ Sore throat ☐ Difficulty swallowing

Lungs: ☐ Wheezing ☐ Shortness of breath ☐ Snoring ☐ Asthma ☐ Waking gasping for breath

Chest/Heart: ☐ Chest pain ☐ Palpitations ☐ Irregular heartbeat ☐ History of Rheumatic fever

Hematology: ☐ Easy bruising ☐ Trouble with blood clotting ☐ Nose bleeds ☐ Miscarriage(s)

GI: ☐ Abdominal pain ☐ Nausea ☐ Vomiting ☐ Heartburn

☐ Change in bowel habits or stool ☐ constipation/diarrhea

Bladder: ☐ Kidney stones ☐ Urinary frequency/urgency ☐ Blood in urine ☐ Prostate issues

Circulation: ☐ Varicose veins ☐ Leg swelling

Musculoskeletal: ☐ Back pain ☐ Joint pain

Neurology: ☐ Headaches ☐ Dizziness ☐ Passing out ☐ Migraines ☐ Stroke

Allergy: ☐ Hives ☐ Rash ☐ Itchiness

Sleep: ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Snoring ☐ Never feel rested

Psychiatric: ☐ Depression ☐ Anxiety ☐ Bipolar

Past Medical History: (check all that apply)

☐ Thyroid Disease	☐ Measles	☐ Tonsillitis	☐ Jaundice
☐ Mumps	☐ Pleurisy	☐ Kidneys	☐ Scarlet Fever
☐ Liver Disease	☐ Lung Disease	☐ Whooping Cough	☐ Chicken Pox
☐ Rheumatic Fever	☐ Bleeding Disorder	☐ Nervous Breakdown	☐ Ulcers
☐ Gout	☐ Anemia	☐ Heart Valve Disorder	☐ Heart Disease
☐ Osteoporosis	☐ Tuberculosis	☐ Gallbladder Disorder	☐ Psychiatric Illness
☐ Drug Abuse	☐ Eating Disorder	☐ Alcohol Abuse	☐ Pneumonia
☐ Typhoid Fever	☐ Cancer	☐ Heart Attack	☐ Seizure Disorder
☐ Glaucoma	☐ Stroke	☐ Cancer	☐ Blood Clot
☐ Diabetes	☐ Atrial Fibrillation/Dysrhythmia		

☐ Other: ____________________

Nutrition Evaluation

Present Weight: ____________ Height (no shoes): ____________ Desired Weight: ______________

In what time frame would you like to be at your desired weight?

Birth Weight: ____________ Weight at 20 years of age: _________________ Weight one year ago: _____________

What is the main reason for your decision to lose weight? ____

____

When did you begin gaining excess weight? (Give reasons, if known): ____

____

What has been your maximum lifetime weight (non-pregnant) and when? ____

____

Previous diets/medication you have done: ____

____

Give dates and results of your weight loss: ____

____

Is your spouse, fiancée or partner overweight? ☐Yes ☐No Are your children overweight? ☐Yes ☐No

By how much is he or she overweight? ____

How often do you eat out? ____

What restaurants do you frequent? ____

How often do you eat "fast foods?" ____

Who plans meals? ___________________ Cooks? __________________ Shops? ______________________

Do you use a shopping list? ☐Yes ☐No

What time of day and on what day do you usually shop for groceries?

Food allergies: ____

Food dislikes: ____

Food(s) you crave: ____

Any specific time of the day or month do you crave food? ____

Do you drink coffee or tea? ☐Yes ☐No How much daily? ___________________

Do you drink cola drinks? ☐Yes ☐No How much daily? ________________________

Do you drink alcohol? ☐Yes ☐No

What?_________________ How much daily?______________________ Weekly?____________________

Do you use a sugar substitute? ☐Yes ☐No Butter? ☐Yes ☐No Margarine? ☐Yes ☐No

Do you awaken hungry during the night? ☐Yes ☐No What do you do? ____________________________

____

What are your worst food habits? ____

____

Snack Habits:

What? ________________________________ How much? __________________ When? __________________

When you are under a stressful situation at work or family related, do you tend to eat more? ☐Yes ☐No

Explain: ____

Do you think you are currently undergoing a stressful situation or an emotional upset? ☐Yes ☐No

Explain: ____

Smoking Habits: (answer only one)

☐You have never smoked ☐You quit smoking years ago ☐You smoke __ cigarettes per day

Typical Breakfast: ______________________ Time Eaten: ________

Where:______________________________ With whom:______________________

Typical Lunch:________________________ Time Eaten: ________

Where:______________________________ With whom:______________________

Typical Dinner: _______________________ Time Eaten: ________

Where:______________________________ With whom:______________________

Describe your usual energy level:

Previous exercise routine/schedule:____

What is your current exercise routine?____

Any exercise limitations?____

____

Activity Level: (answer only one)

☐Inactive: no regular physical activity with a sit-down job.

☐Light activity: no organized physical activity during leisure time.

☐Moderate activity: occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

☐ Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week..

☐Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior style: (answer only one)

☐ You are always calm and easygoing.

☐ You are usually calm and easygoing.

☐ You are sometimes calm with frequent impatience.

☐ You are seldom calm and persistently driving for advancement.

☐ You are never calm and have overwhelming ambition.

☐ You are hard-driving and can never relax.

Mental Health

Have you ever been diagnosed or treated for Anxiety or Depression? ☐ Yes ☐ No

Have you ever been treated or diagnosed with an Eating Disorder? (Anorexia, Bulimia, Binge Eating) ☐ Yes ☐ No

Night Eating Syndrome) ☐ Yes ☐ No

Do you panic when stressed? ☐ Yes ☐ No

Do you cry frequently? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

Have you ever seen a counselor? ☐ Yes ☐ No

Please describe your general health goals and improvements you wish to make: ____

____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. By signing this form, I am indicating all health history is accurate and correct.

Signed: ____ Date: ______________________