

## NEW PATIENT MEDICAL HISTORY FORM

Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Phone: (Home/Cell) \_\_\_\_\_ (Work) \_\_\_\_\_ Gender: M / F

Referred By: \_\_\_\_\_

How does your weight affect your life and health? \_\_\_\_\_

### Weight History

When did you become overweight?

Childhood  Teens  Adulthood  Pregnancy  Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? \_\_\_\_\_

As best you can remember, how much did you weigh one year ago? \_\_\_\_\_

Five years ago? \_\_\_\_\_ 10 years ago? \_\_\_\_\_

Triggers for your weight gain (check all that apply):

Stress  Marriage  Divorce  Illness  Medication abuse  Travel  Injury  
 Nightshift work  Insomnia  Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):

Weight Watchers  Nutrisystem  Jenny Craig  LA Weight Loss  Atkins  
 South Beach  Zone diet  Medifast  Dash diet  Paleo diet  
 HCG diet  Mediterranean diet  Ornish diet  Other: \_\_\_\_\_

What was your maximum weight loss? \_\_\_\_\_

What are your greatest challenges with dieting? \_\_\_\_\_

Have you ever taken medication to lose weight? (check all that apply):

Phentermine (Adipex)  Meridia  Xenecal/Alli  Phen/Fen  
 Phendimetrazine (Bontril)  Topamax  Saxenda  Diethylpropion  
 Bupropion (Wellbutrin)  Belviq  Qsymia  Contrave

Other: \_\_\_\_\_

What worked? \_\_\_\_\_

What didn't work? \_\_\_\_\_

Why or why not? \_\_\_\_\_

### Nutritional History

How often do you eat breakfast? \_\_\_\_\_ days per week at \_\_\_\_\_:\_\_\_\_\_ a.m.

Number of times you eat per day: \_\_\_\_\_

Do you get up at night to eat? Y / N If so, how often? \_\_\_\_\_ times

Daily servings of: Vegetables \_\_\_\_\_ Fruits \_\_\_\_\_ Meat \_\_\_\_\_ Dairy \_\_\_\_\_

Sweet beverages (check all that apply):

Soda  Juice  Sweet tea  Coffee/tea If so, how many times per day? \_\_\_\_\_

Number of times per week you eat fast food: Breakfast \_\_\_\_\_ Lunch \_\_\_\_\_ Dinner \_\_\_\_\_

Eating triggers (check all that apply):

- Stress     Boredom     Anger     Seeking Reward     Parties     Eating Out  
 Fast Food     Other: \_\_\_\_\_

Food cravings:

- Sugar     Chocolate     Starches     Salty     High Fat     Large Portions

Favorite foods: \_\_\_\_\_

### **Medical History**

Exercise type: \_\_\_\_\_

Duration: \_\_\_\_\_ hours \_\_\_\_\_ minutes    Number of times per week: \_\_\_\_\_

What prevents you from exercising? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_    How times do you get up during the night? \_\_\_\_\_

Do you feel rested in the morning? \_\_\_\_\_

Past medical history (check all that apply):

- |  |  |   |                                      |
|--|--|---|--------------------------------------|
| <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Angina                      | <input type="checkbox"/> Gall bladder stones          | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Indigestion/reflux arthritis | <input type="checkbox"/> Thyroid     |
| <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Celiac disease               | <input type="checkbox"/> Anxiety     |
| <input type="checkbox"/> High triglycerides  | <input type="checkbox"/> Gout                        | <input type="checkbox"/> Pancreatitis                 | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Infertility         | <input type="checkbox"/> Polycystic Ovarian Syndrome |   |                                      |
- Cancer (type/s): \_\_\_\_\_

Have you ever be diagnosed with an eating disorder? Y / N    If yes, which one? \_\_\_\_\_

Past surgical history (check all that apply):

- Gastric bypass     Gastric banding     Gastric sleeve     Gall bladder     Heart bypass  
 Hysterectomy     Other: \_\_\_\_\_

Medications (list all current medications and dosages):

\_\_\_\_\_  
\_\_\_\_\_

Allergies:

(Medications) \_\_\_\_\_

(Food) \_\_\_\_\_

### **Social History**

Smoking:     Never     Current smoker (\_\_\_\_\_ packs/day)     Past smoker (quit \_\_\_\_\_ years ago)

Alcohol:     Never     Occasional     Regularly (\_\_\_\_\_ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs:     Never     Current     Past     Type of drugs: \_\_\_\_\_

Marijuana:     Never     Current user (\_\_\_\_\_ times/day)

### **Family History**

- Obesity (check all that apply):     Mother     Father     Sister     Brother  
    Daughter     Son
- Diabetes (check all that apply):     Mother     Father     Sister     Brother  
    Daughter     Son
- Other (check all that apply):     High blood pressure     Heart disease     High cholesterol  
 High triglycerides     Stroke     Thyroid problems     Anxiety     Depression  
 Bipolar disorder     Alcoholism     Cancer (type/s): \_\_\_\_\_  
Other: \_\_\_\_\_

### **Gynecologic History**

- Age periods started? \_\_\_\_\_ Age periods ended \_\_\_\_\_  
Periods are: Regular / Irregular Heavy / Normal / Light  
Number of pregnancies: \_\_\_\_\_ Number of children: \_\_\_\_\_  
Age of first pregnancy: \_\_\_\_\_ Age of last pregnancy: \_\_\_\_\_

### **System Review**

(Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Recent weight loss more than 10 pounds |  |   |
| <input type="checkbox"/> Recent weight gain more than 10 pounds |  |   |
| <input type="checkbox"/> Acne                                   | <input type="checkbox"/> Skin rash                 | <input type="checkbox"/> Cough              |
| <input type="checkbox"/> Snoring                                | <input type="checkbox"/> Shortness of breath       | <input type="checkbox"/> Chest pain         |
| <input type="checkbox"/> Difficulty breathing when flat         | <input type="checkbox"/> Fainting/Blacking out     | <input type="checkbox"/> Palpitations       |
| <input type="checkbox"/> Swelling ankles/extremities            | <input type="checkbox"/> Abdominal pain            | <input type="checkbox"/> Bloating           |
| <input type="checkbox"/> Constipation                           | <input type="checkbox"/> Diarrhea                  | <input type="checkbox"/> Food intolerance   |
| <input type="checkbox"/> Dysphagia/difficulty swallowing        | <input type="checkbox"/> Indigestion               | <input type="checkbox"/> Nausea/vomiting    |
| <input type="checkbox"/> Increased appetite                     | <input type="checkbox"/> Decreased appetite        | <input type="checkbox"/> Heartburn          |
| <input type="checkbox"/> Gas and bloating                       | <input type="checkbox"/> Urinary frequency/urgency | <input type="checkbox"/> Slow urine flow    |
| <input type="checkbox"/> Nighttime urination                    | <input type="checkbox"/> Loss of urine control     | <input type="checkbox"/> Blood in stools    |
| <input type="checkbox"/> Back pain (upper)                      | <input type="checkbox"/> Back pain (lower)         | <input type="checkbox"/> Joint pain         |
| <input type="checkbox"/> Muscle aches/pain                      | <input type="checkbox"/> Dizziness                 | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Seizures                               | <input type="checkbox"/> Weakness/low energy       | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Depression                             | <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Memory loss        |
| <input type="checkbox"/> Inability to concentrate               | <input type="checkbox"/> Mood changes              | <input type="checkbox"/> Nervousness        |
| <input type="checkbox"/> Loss of interest                       | <input type="checkbox"/> Cold intolerance          | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Hair changes                           | <input type="checkbox"/> Heat intolerance          | <input type="checkbox"/> Blood clots        |
| <input type="checkbox"/> Fatigue/tiredness                      |  |   |

### **(Men only)**

- Difficulty with erections     Loss of interest in sex     Low testosterone

### **(Women only)**

- Absence of periods     Hot flashes     Change in bladder habits  
 Abnormal/excessive menstruation     Facial hair     Loss of interest in sex  
 Difficulty getting pregnant

Comments: \_\_\_\_\_