



GH CLINICS

WEIGHT MANAGEMENT PROGRAM

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? _____

NUTRITIONAL HISTORY, CONTINUED

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: _____

ALCOHOL USE

How many drinks per week (on average) _____

What kind of drinks do you prefer? _____

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):

- Heart attack Angina Gall bladder stones Sleep apnea
- High blood pressure Stroke Indigestion/reflux arthritis Thyroid
- High cholesterol Diabetes Celiac disease Anxiety
- High triglycerides Gout Pancreatitis Depression
- Infertility 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"/> Skin rash | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Recent weight gain more than 10 pounds | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Fainting/Blacking out | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Difficulty breathing when flat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Food intolerance |
| <input type="checkbox"/> Swelling ankles/extremities | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Dysphagia/difficulty swallowing | <input type="checkbox"/> Urinary frequency/urgency | <input type="checkbox"/> Slow urine flow |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Loss of urine control | <input type="checkbox"/> Blood in stools |
| <input type="checkbox"/> Gas and bloating | <input type="checkbox"/> Back pain (lower) | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Nighttime urination | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Back pain (upper) | <input type="checkbox"/> Weakness/low energy | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Muscle aches/pain | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Mood changes | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Cold intolerance | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> Inability to concentrate | <input type="checkbox"/> Heat intolerance | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Loss of interest | | |
| <input type="checkbox"/> Hair changes | | |
| <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: _____