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 first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

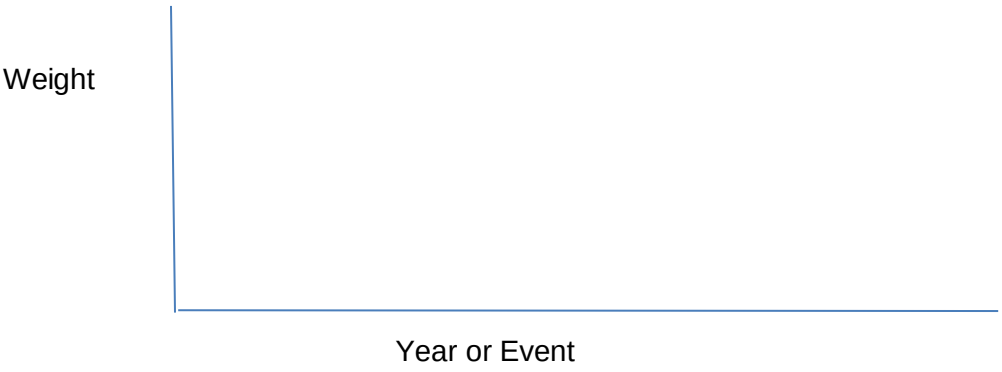
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? _____

How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

Life events associated with weight gain (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness
☐ Travel ☐ Injury ☐ Nightshift work ☐ Job change ☐ Quitting smoking
☐ Alcohol ☐ Drugs
☐ Medication (please list: _____

Draw a chart. Note anything you feel has been significant to help you lose weight or reasons you might have gained weight. Label your weight on left axis and note year or specific event on the line across bottom.



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 (including supplements): _____
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: _____ What beverages do you drink? _____
Do you get up at night to eat? Y / N If so, how often? _____ times
List any food intolerances/restrictions: _____
Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Other: _____

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food
☐ High fat ☐ Large portions

Favorite foods: _____

Medical History

Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gallbladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Arthritis ☐ Polycystic Ovarian Syndrome ☐ Bipolar
☐ Glaucoma ☐ Cancer (type/s): _____

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

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)

☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds

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

(Women only)

☐ Absence of periods	☐ Hot flashes	☐ Change in bladder habits
☐ Abnormal/excessive menstruation	☐ Facial hair	

Comments: _____

_____

_____