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 □ Wegovy
□ 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):
□ 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)

□ 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 □ Loss of urine control □ 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

(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: _____