**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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):

🞏 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_