New Patient Medical History Form

Name: (First)____________________ (Last)______________________ (MI)______

Referred By: ____________________

How does your weight affect your life and health?

____

____

What are your greatest challenges with dieting?

____

____

Weight History

- **When did you first notice that you were gaining weight?**
  ☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
- **What was your Highest weight?** ______ **When?** ___________________
- **Life events associated with weight gain** (circle all that apply):
  Marriage Divorce Pregnancy Abuse Illness Travel
  Injury Night Shift Work Job Change Quitting Smoking
  Alcohol Drugs Medication: ___________________________

- **Previous Weight Loss Programs** (circle all that apply):
  Weight Watchers Nutrisystem Jenny Craig LA Weight Loss Atkins
  South Beach Zone Diet Medifast DASH Diet Paleo
  HCG Diet Ornish Keto Mediterranean
  Other: ___________________________

- **Have you ever taken medication to lose weight?** (circle all that apply)
  Phentermine Meridia Xenecal/Alli Phen/Fen Belviq
  Phendimetrazine Topamax Saxenda Diethylpropion Bupropion
  Qsymia Contrave Other (including supplements):______________________
  *What worked?*____
  What didn't work? ____
  Why or why not? ____

Nutritional History

- **List any food allergies/intolerances/restrictions:** _____________________________________
- **Food Triggers:** (circle all that apply)
  Stress Boredom Anger Insomnia Seeking Reward
  Parties Eating Out Other:____________________________________

- **Food Cravings:** (circle all that apply)
  Sugar Chocolate Starches Salty Fast Foods High Fat
  Large Portions **Favorite Foods**:______________________________________

Medical History

- **Does anything limit you from exercising?**_______________________________________
- **How many hours do you sleep per night?** _____

- **Past Medical History:** (circle all that apply)

Heart attack	Angina	Gallbladder stones	Sleep apnea	Asthma
Glaucoma	Infertility	Indigestion/Reflux	Celiac disease	Thyroid
Pancreatitis	Stroke	High blood pressure	Diabetes	Anxiety
Depression	Bipolar	High Cholesterol	Arthritis	Gout
Cancer	PCOS	High Triglycerides	Other:__________________	

Have you ever been diagnosed with an eating disorder? *Yes:*__________________ *No*

- **Past Surgical History:** (circle 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)

Are you currently allergic to any medications? Yes: ______________ **No**

Social History (circle all that apply)

Smoking: Never Current smoker (________packs/day) Past smoker(________ years quit)
Alcohol: Never Occasional Regularly (______ drinks per week)
Prior treatment for alcoholism? Y/N
Drugs: Never Current Past Types of drug(s):________________________
Marijuana: Never Current user (_________ times/day)

Family History
Obesity (circle all that apply): Mother Father Sister Brother Daughter Son
Diabetes (circle all that apply): Mother Father Sister Brother Daughter Son

Other Family History (circle all that apply):

High Blood Pressure   Heart Disease   High Cholesterol
High Triglycerides   Stroke   Thyroid Problems   Anxiety   Depression
Bipolar Disorder   Alcoholism   Cancer(type(s)_______________

System Review (circle all that apply)

Constitutional:
Increased appetite
Fatigue/tiredness
Fever

Endocrine:
Cold Intolerance
Heat Intolerance

Respiratory:
Shortness of breath

Cardiovascular:
Chest Pain
Swelling(Ankles/feet)
Palpitations

GI:
Gas/bloating
Abdominal pain
Blood in stools
Constipation
Diarrhea
Difficulty swallowing
Heartburn
Nausea/vomiting

Musculoskeletal:
Back pain
Muscle aches
Joint pain

Peripheral Vascular:
Blood clots

Psychiatric:
Loss of interest
Inability to concentrate
Mood changes
Anxiety
Depression

Neurological:
Fainting/blacking out
Headaches
Memory loss
Seizures