



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 Belvia
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