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: _____)

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:
(Medication Allergies) _____
(Food Allergies) _____

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 ☐ Stroke
☐ High triglycerides ☐ 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: _____
_____
_____