PATIENT MEDICAL HISTORY FORM — CURRENT PATIENT

MMC weight loss AND WELLNESS

Name: _____

DOB:_____ Sex: ☐M ☐F

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Work Phone: _____

Cell Phone:_____ Email: _____

Emergency Contact:_____ Phone: _____

Primary Care Physician:_____ Phone: _____

How did you hear about us? _____

For Office Use Only:

Date:_____

Chart # _____

Goal _____

Weight:_____

Start Weight _____

Chest:_____

Waist: _____

Hip: _____

Waist/Hip Ratio: _____

Reviewed by:_____

Present Status:

Are you in good health at the present time to the best of your knowledge? ☐Yes ☐No

Explain a "no" answer: _____

_____

Are you under a doctor's care at the present time? ☐Yes ☐No

If yes, for what? _____

Do you have a Pacemaker_____ Neurostimulator_____ Any other medical implanted device _____

Are there any changes to your medical history (medications, allergies, surgeries, problems) since you were last seen in the clinic? ☐Yes ☐No

History of High Blood Pressure? ☐Yes ☐No

History of Diabetes? ☐Yes ☐No At what age: _____

History of Heart Attack or Chest Pain or other heart condition? ☐Yes ☐No

History of Swelling Feet? ☐Yes ☐No

History of Frequent Headaches? ☐Yes ☐No

Migraines? ☐Yes ☐No Medications for Headaches: _____

History of Constipation (difficulty in bowel movements)? ☐Yes ☐No

History of Glaucoma? ☐Yes ☐No

History of Sleep Apnea? ☐Yes ☐No

If "yes", do you wear your CPAP? ☐Yes ☐No

Gynecologic History:

Are they regular: ☐Yes ☐No

Pain associated: ☐Yes ☐No

Last menstrual period: _____

Birth Control Method: _____

Review of Systems: (Check all that apply)

General: ☐Fatigue ☐Night Sweats ☐Unexplained weight change

Eyes: ☐Visual trouble ☐Trouble with eye pressure ☐Eye redness/discharge

Ears: ☐Difficulty hearing ☐Ringing in ears

Nose: ☐Chronic discharge/drainage

Throat: ☐Sore throat ☐Difficulty swallowing

Lungs: ☐Wheezing ☐Shortness of breath ☐Snoring ☐Asthma ☐Waking gasping for breath

Chest/Heart: ☐Chest pain ☐Palpitations ☐Irregular heartbeat ☐History of Rheumatic fever

Hematology: ☐Easy bruising ☐Trouble with blood clotting ☐Nose bleeds Miscarriage(s)

GI: ☐Abdominal pain ☐Nausea ☐Vomiting ☐Heartburn

☐Change in bowel habits or stool constipation/diarrhea

Bladder: ☐Kidney stones ☐Urinary frequency/urgency ☐Blood in urine ☐Prostate issues

Circulation: ☐Varicose veins ☐Leg swelling

Musculoskeletal: ☐Back pain ☐Joint pain

Neurology: ☐Headaches ☐Dizziness ☐Passing out ☐Migraines ☐Stroke

Allergy: ☐Hives ☐Rash ☐Itchiness

Sleep: ☐Trouble falling asleep ☐Trouble staying asleep ☐Snoring ☐Never feel rested

Psychiatric: ☐Depression ☐Anxiety ☐Bipolar

Nutrition Evaluation

What is the main reason for your decision to lose weight? _____

_____

_____

_____

What has been your maximum lifetime weight (non-pregnant) and when? _____

_____

_____

_____

Previous diets/medication you have done: _____

_____

_____

_____

Who lives in your home?_____

_____

Is your spouse, fiancée or partner overweight? ☐Yes ☐No

Are your children overweight? ☐Yes ☐No

How often do you eat "fast foods?" _____

Food allergies: _____

Food dislikes: _____

Food(s) you crave: _____

Do you drink coffee or tea? ☐Yes ☐No How much daily? _____

Do you drink cola drinks? ☐Yes ☐No

How much daily? _____

Do you drink alcohol? ☐Yes ☐No

What?_____ How much daily?_____ Weekly?_ _____

Do you use a sugar substitute? ☐Yes ☐No

Do you awaken hungry during the night? ☐Yes ☐No What do you do? _____

_____

What are your worst food habits? _____

_____

Snack Habits:

What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? ☐Yes ☐No

Explain: _____

Do you think you are currently undergoing a stressful situation or an emotional upset? ☐Yes ☐No

Explain: _____

Smoking Habits: (answer only one)

☐You have never smoked ☐You quit smoking years ago ☐You smoke __ cigarettes per day

Typical Breakfast: _____ Time Eaten: _____

Where: _____ With whom: _____

Typical Lunch: _____ Time Eaten: _____

Where: _____ With whom:_ _____

Typical Dinner: _____ Time Eaten: _____

Where: _____ With whom: _____

What is your current exercise routine? _____

Any exercise limitations?_____

_____

Mental Health

Have you ever been diagnosed or treated for Anxiety or Depression? ☐Yes ☐No

Have you ever been treated or diagnosed with an Eating Disorder? (Anorexia, Bulimia, Binge Eating) ☐Yes ☐No

Night Eating Syndrome? ☐Yes ☐No

Do you panic when stressed? ☐Yes ☐No

Do you cry frequently? ☐Yes ☐No

Have you ever attempted suicide? ☐Yes ☐No

Have you ever seen a counselor? ☐Yes ☐No

Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

_____

_____

Goal Weight: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. By signing this form,

I am indicating all health history is accurate and correct.

Signed: _____ Date: _____