Weight Management Clinic
Patient Medical History Form

Name: _____ Age: _____ Sex: M F

Are you in good health? Yes No
If no, please comment:

Are you under a doctor's care? Yes No
If yes, please comment:

Are you taking any medications? Yes No
If YES, please list both prescription and non-prescription
Medication Dosage:

Hormone Replacement Therapy: Yes No
What are you taking:

Any allergies to any medications? Yes No
Please list:

Medical History: (Do you have or have you had any of the following?

_____ High blood pressure	_____ Diabetes	_____ Glaucoma
_____ Jaundice	_____ Heart Disease	_____Angina
_____ Kidney Disease	_____ Heart Attack	_____ Liver Disease
_____ Lung Disease `	_____ Stroke	_____Seizures
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____Stomach Ulcers	_____ Gout	_____ Thyroid Condition
_____ Anemia	_____ Heart Valve problem	_____ Heart Disease
_____Sleep apnea	_____ Gallbladder Disease	_____ Psychiatric Illness
_____ Drug Addiction	_____ Eating Disorder	_____ Alcohol Addiction
_____ Immune Disorder	_____ Yeast infections	_____Thyroid tumors
_____ Migraines	_____ Cancer	_____Fatty Liver Disease
_____ Arthritis	_____ Osteoporosis	_____ Gallbladder disease
_____ Gastrointestinal disease		_____ Neurological disorder
_____ H. Pylori infection	_____ Digestive disorder	_____ Celiac Disease
_____ Gluten sensitivity	_____ Lactose intolerance	_____ Anorexia
_____ Bulimia	_____ High Cholesterol	_____ Depression
_____ Suicide attempt	_____ Autoimmune disease	_____ Grave's Disease
_____ Blood clot	_____ Diverticulitis	_____ Gastric bypass
_____ Stomach surgery	_____ Anxiety attacks	_____Pacemaker
_____ Panic attacks	_____Kidney stones	_____ Low white Cell count
_____ Hysterectomy	_____ Heart surgery	_____ Irritable Bowel
_____ Asthma	_____ COPD/emphysema	
_____Polycystic Ovarian Syndrome		

May comment here:

Gynecologic History: for Women

Are you currently trying to get pregnant? _____

Menstrual cycle: Regular: Yes No

Birth Control: No Yes: What Type: _____

Last Gyn Check Up: _____

*****if you are currently pregnant or breastfeeding, please call Dr. Romero before making an appointment**

Any Major Surgery: Yes No

Specify: (List all) Date

Symptom Review: Have you had any of these symptoms in the past month?

	Yes	No		Yes	No
Jittery			Tiredness		
Nervous			Memory problems		
Anxiety			Word finding problems		
Always sleepy			Dizziness		
Tingling or numbness			Balance problems		
Depression			Abdominal pain		
Nausea					
Heart palpitations			Coordination problems		
Heart racing			Blurry Vision		
Insomnia			Eye pain		
Tremors			Ringing in ears		
Blood in your urine					
Vomiting			Double vision		
Dry mouth			Constipation		
Diarrhea			Shortness of breath		
Chest pain			Headaches		
Feel cold all the time			Feel hot all the time		
Losing hair beyond normal					
Crave carbs (bread, pasta)			Crave sweets		
Foggy brain			Very dry skin		
Hungry all the time			Binge eating episodes		
Decreased libido			Feel sluggish		
			Heartburn/Acid reflux		
Frequent burping			Leg cramps		
Abdominal bloating			Abdominal pain after eating		
Missed menses			Swollen ankles/feet		
Mood changes/irritability			Hot flashes/Excessive sweating		
			Joint pain		
Exhaustion			Burned out		
Store fat in front of stomach			Snoring		
Emotional/cry easily			Fatigue, especially in afternoon		
Craving salt			Fatigue, all day long		
Can’t handle stress anymore					

Family History: Has any blood relative ever had any of the following:

Glaucoma	Yes	No	Who: _____
Epilepsy	Yes	No	Who: _____
Kidney Disease	Yes	No	Who: _____
Diabetes	Yes	No	Who: _____
Eating Disorder	Yes	No	Who: _____
Heart Disease/Stroke	Yes	No	Who: _____
Cancer	Yes	No	Who: _____
Genetic abnormality	Yes	No	Who: _____
Weight problems	Yes	No	Who: _____
Thyroid tumors	Yes	No	Who: _____

1. Present Weight: _____ Height: _____ Desired Weight: _____

2. How long do you think it will take you to get to your desired weight? _____

3. Birth Weight: _____ Weight at age 20?: _____ Weight one year ago: _____

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

5. When did you begin gaining excess weight? (Give reasons, if known): _____

   _____

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

7. Previous diets/programs you have followed: Approximate date and results:

8. How often do you eat out? _____

9. How often do you eat "fast foods?" _____

10. Who plans meals? _____ Cooks? _____ Shops? _____

11. Food allergies: _____

12. Food dislikes: _____

13. Food(s) you crave: _____

14. Any specific time of the day or month do you crave food? _____

15. Do you drink coffee or tea? No Yes How much? _____

16. Do you drink soda drinks? No Yes How much? _____

17. Do you drink alcohol? No Yes How much?_____

18. Do you use a sugar substitute? No Yes Which one?_____

19. Do you wake up hungry during the night? Yes No

    What do you do? _____

20. What are your worst food habits? _____

21. Snack Habits: What, how much, and when?

22. When you are in a stressful situation do you tend to eat more? Comment:

    _____

    _____

23. Are you currently undergoing a stressful situation? Comment

    _____

    _____

24. Typical Breakfast _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

Typical Lunch _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

Typical Dinner _____ _____ _____ _____
Time eaten: _____
Where: _____
With whom: _____

25. Do you sleep 8 hours a night? Yes/No
Describe our usual sleep pattern:

26. Describe your usual energy level: _____

Rate your energy level: (Low) 1 2 3 4 5 (excellent)

27. Smoking Habits: No Yes, describe_____

28. Activity Level: **(**check one**)**
____ Inactive—no physical activity and a sit-down job.
____ Light activity—minimal activity
____ Moderate activity—activities such as golf, tennis, jogging, swimming or cycling.
____Heavy activity—consistent lifting, stair climbing, heavy construction, or regular Jogging/running, swimming, cycling or active sports at 3 to 5 times per week
_____Vigorous activity--extensive exercise for one hours, 4-7 times per week.

29. Behavior style: **(**check one)
____ You are always calm and easygoing.
____ You are usually calm and easygoing.
____ You are frequently impatient
____ You are seldom calm
____ You are never calm
___ Other:

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

_____

_____

_____