Weight Management Clinic
Patient Medical History Form

Name: _____ Age:_____ F M

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

Please list all medications you take, prescription and non-prescription:

Any allergies to medications? Yes No
Please list:

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

_____ High blood pressure	_____ Diabetes	_____ Pre-diabetes
_____ Heart Disease	_____Angina	_____Glaucoma
_____ Kidney Disease	_____ Heart Attack	_____ Liver Disease
_____ Lung Disease `	_____ Stroke	_____Seizures
_____ Rheumatic Fever	_____ Bleeding Disorder	
_____Stomach Ulcers	_____ Gout	_____ Thyroid Condition
_____ Anemia	_____ Heart Valve problem	_____Thyroid Tumors
_____Sleep apnea	_____ Gallbladder Disease	_____ Drug Addiction
	_____ Eating Disorder	_____ Alcohol Addiction
_____ Immune Disorder	_____ Yeast infections	_____Thyroid tumors
_____ Migraines	_____ Cancer	_____Fatty Liver Disease
_____ Arthritis	_____ Osteoporosis	_____ Pancreatitis
_____ Neurological disorder		_____Stomach Surgery
_____ H. Pylori infection	_____ Celiac Disease	_____Gastric Reflux (Gerd)
_____ Gluten sensitivity	_____ Lactose intolerance	_____Esophagus surgery
_____ Bulimia	_____ High Cholesterol	_____ Depression
_____ Suicide attempt	_____ Grave's Disease	_____Diabetic Eye Disease
_____ Blood clot	_____ Gastric bypass	_____Anorexia
_____ Stomach surgery	_____ Anxiety attacks	_____Pacemaker
_____ Panic attacks	_____Kidney stones	_____ Low white Cell count
_____ Heart surgery	_____ Irritable Bowel	
_____ Asthma	_____Polycystic Ovarian Syndrome (PCOS)	

Comment:

Gynecologic History (Women): Are you currently trying to get pregnant? _____
Birth Control: No Yes: What Type: _____

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

Any Surgery: Yes No

List here:

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

	Yes		Yes
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	
Can't Handle stress anymore		Joint pain	
Exhaustion		Burned out	
Store fat in front of stomach		Snoring	
Emotional/cry easily		Fatigue	
Craving salt			

Family History:

Diabetes Yes No Who: _____

Weight problems Yes No Who:_____

Weight History:

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

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

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

3. When did you begin gaining excess weight?

4. Previous diets/programs Approximate date and results: (did you lose weight?)

5. How often do you eat out or eat "fast foods"?

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

7. Food allergies?_____

8. Food dislikes?_____

9. Food(s) you crave? _____

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

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

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

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

14. What is your worst food habit? _____

15. Snack Habits: (describe)

16.

Typical Breakfast	Typical Lunch	Typical Dinner

17. When you are in a stressful situation do you tend to eat more?

18. Are you currently in a stressful situation?

19. Do you sleep 8 hours a night? Yes/No

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

21. Smoking Habits: None Yes, describe_____

22. 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; 3 or more times a week
    ____Heavy activity—consistent lifting, stair climbing, heavy construction, or regular Jogging/running, swimming, cycling or active sports at 5 to 7 times per week
    _____Vigorous activity--extensive exercise for one hour, 4-7 times per week.

23. 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:

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