Weight Management Clinic
Patient Medical History Form

Name: ______________________________________ Age:__________________ F M

Medical History: Do you have or have you had any of the following? If yes, please describe in the section below.

YES NO

☐ ☐ Heart disease—pacemaker, defibrillator, heart attack, angina, palpitations, heart valve disease

☐ ☐ High blood pressure

☐ ☐ Anxiety/panic attacks

☐ ☐ Taking medications for depression

☐ ☐ Currently pregnant or breast feeding or trying to get pregnant

☐ ☐ Using contraception (IUD or OCP) or hysterectomy or tubal or nothing? (circle one)

☐ ☐ Taking a narcotic pain medication

☐ ☐ Allergic to sulfa medications

☐ ☐ Occupation: ____________________drug screen required? Yes or No (circle one)

☐ ☐ Thyroid: cysts or nodules or tumor or cancer

☐ ☐ Personal or family history of Multiple Endocrine Neoplasia

☐ ☐ Kidney stones or kidney disease

☐ ☐ Seizures, current or in the past

☐ ☐ Migraines

☐ ☐ Pancreatitis

☐ ☐ Gallbladder disease

☐ ☐ Glaucoma

☐ ☐ Gastrointestinal: bariatric surgery, and GI surgery, hiatal hernia, reflux, stomach ulcers

☐ ☐ Diabetes ___Prediabetes _____Gestational DM ____FHx Diabetes

☐ ☐ Diabetic eye disease (retinopathy)

If yes to any of the above, please describe here:

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:

Do you have any of the following additional conditions?

_______ Liver Disease	_______PCOS (Polycystic Ovarian Syndrome)
_______ Lung Disease `	_______ Stroke
_______ Rheumatic Fever	_______ Bleeding Disorder
_______ Gout	_______Asthma
_______ Anemia	_______Alcohol addiction/dependence
_______Sleep apnea	_______ Drug Addiction/dependence
_______Depression	_______ Eating Disorder
_______ Immune Disorder	
_______ Cancer	_______Fatty Liver Disease
_______ Arthritis	_______ Osteoporosis
_______ Neurological disorder	
_______ H. Pylori infection	_______ Celiac Disease
_______ Gluten intolerance	_______ Lactose intolerance
_______ Bulimia	_______ High Cholesterol
_______ Suicide attempt	_______Anorexia
_______ Blood clot	_______ Low white Cell count
_______ Irritable Bowel	

Comment on any of the above:

Any Surgery: Yes No

List here:

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

	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	
		Snoring	
Emotional/cry easily		Fatigue	
Craving salt			

Comment here on any symptoms?

Family History: Any conditions that run in your family that the doctor should be aware of?

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/Medications used: 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?________________________________

14. Do you drink energy drinks?No Yes How much?________________________________

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

15. What is your worst food habit? ____

16. Snack Habits: (describe)

17. Typical Breakfast / Typical Lunch / Typical Dinner

Typical Breakfast	Typical Lunch	Typical Dinner
_______________________	____________________	__________________________
_______________________	____________________	__________________________
_______________________	____________________	__________________________
_______________________	____________________	__________________________

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

19. Are you currently in a stressful situation?

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

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

22. Smoking Habits: None Yes, describe________________________________

23. Current Activity Level: (check one)

____ *Inactive*—no physical activity and a sitting/desk job.
____ *Light activity*—minimal activity, occasional walk or stroll
____ *Moderate activity*—activities such as golf, tennis, jogging swimming or cycling; 2-3 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 daily exercise for one hour or more, 5-7 times per week.

24. 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:

25. Rate your current motivation level. On a scale from 1 to 5, how motivated are you right now to lose weight?

(Low) 1 2 3 4 5 (high)

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