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 is 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 ☐ Intermittent Fasting ☐ 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 ☐ Wegovy
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion ☐ Plenity
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave ☐ Tirzepatide
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: _____

How much water do you drink each day? _____ oz/day

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? _____
Do you snore? Yes / No Do you wear a CPAP? Yes / No

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:
(Medications)_____
(Food)_____

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 ☐ High triglycerides ☐ Stroke ☐ 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	☐ Vision Changes	☐ Skin rash
☐ Cough	☐ Chest Pain	☐ Difficulty breathing
☐ Snoring	☐ Difficulty breathing when flat	☐ Fainting/Blacking out
☐ Palpitations	☐ Swelling ankles/extremities	☐ Abdominal pain
☐ Bloating	☐ Constipation	☐ Diarrhea
☐ Food intolerance	☐ Indigestion	☐ Nausea/vomiting
☐ Dysphagia/difficulty swallowing	☐ 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	☐ Loss of interest in sex	

(Women only)

☐ Absence of periods	☐ Hot flashes	☐ Change in bladder habits
☐ Abnormal/excessive menstruation	☐ Facial hair	☐ Difficulty getting pregnant
☐ Easy bruising	☐ Sensitive fat tissue	

(Men only)

☐ Difficulty in getting erections ☐ Low testosterone

Comments: _____

_____

_____