**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 🞏 LA Weight Loss 🞏 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

🞏 Phendimetrazine (Bontril) 🞏 Topamax 🞏 Saxenda 🞏 Diethylpropion

🞏 Bupropion (Wellbutrin) 🞏 Belviq 🞏 Qsymia 🞏 Contrave

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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? \_\_\_\_\_

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 🞏 Skin rash 🞏 Cough

🞏 Snoring 🞏 Shortness of breath 🞏 Chest pain

🞏 Difficulty breathing when flat 🞏 Fainting/Blacking out 🞏 Palpitations

🞏 Swelling ankles/extremities 🞏 Abdominal pain 🞏 Bloating

🞏 Constipation 🞏 Diarrhea 🞏 Food intolerance

🞏 Dysphagia/difficulty swallowing 🞏 Indigestion 🞏 Nausea/vomiting

🞏 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

**(Women only)**

🞏 Absence of periods 🞏 Hot flashes 🞏 Change in bladder habits

🞏 Abnormal/excessive menstruation 🞏 Facial hair

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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