Physician's Weight Control and Wellness Centers

PATIENT MEDICAL HISTORY

Today's Date: _____

Patient's Last Name:	First:		Middle:	Preferred Name:
Date of Birth:	Age:	Sex:	Marital Status:	Social Security # (opt)
Street Address:			City and State:	Zip Code:
Home Phone:	Cell Phone:		E-mail Address:	
Occupation:	Job Title:		How Long:	Work Phone:
Employer:	Employer's Address:			
Spouse's Name:	Spouse's Employer:			Spouse's Work Phone:
Relative other than at your home address:			Relationship:	Phone Number:
Children's Names and Ages:				How did you hear about us?

PATIENT HISTORY (*please check all that apply*)

General

- ☐ Unplanned Weight Change
- ☐ Fevers
- ☐ Chills
- ☐ Sweats
- ☐ Loss of Energy
- ☐ Fatigue

Head / Ears / Nose / Throat

- ☐ Visual Problems
- ☐ Glasses / Contacts
- ☐ Cataracts
- ☐ Hearing Problems
- ☐ Sore Throat
- ☐ Sinus Infection

Pulmonary

- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of Breath
- ☐ Positive TB Test
- ☐ Snoring
- ☐ Headache upon Waking
- ☐ Fall Asleep at Wheel
- ☐ Asthma
- ☐ Never Feel Rested
- ☐ Sleep Study Done
  Results: _____
- ☐ Insomnia

Cardiac

- ☐ Chest Pain with Exertion
- ☐ Chest Pressure
- ☐ Irregular Heart Beat
- ☐ Palpitations
- ☐ Congestive Heart Failure
- ☐ Rheumatic Fever

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Trouble Swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Dark / Black Stool
- ☐ Yellow Jaundiced
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bright Red Blood in Stool
- ☐ Hemorrhoids
- ☐ Stomach Ulcers
- ☐ Heartburn or Reflux

Genitourinary

- ☐ Blood in Urine
- ☐ Hesitancy
- ☐ Kidney Stones
- ☐ Frequent Urination
- ☐ Prostate Problems
- ☐ Discomfort-Urination

Metabolic

- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Thyroid Problems
- ☐ Other _____
  _____

Hematological

- ☐ Abnormal Bleeding
- ☐ Easy Bruising
- ☐ Blood Clots in Legs/Lungs
- ☐ HIV, AIDS
- ☐ Nose Bleeds
- ☐ Hepatitis B
- ☐ Hepatitis C

Neurological

- ☐ Severe Headaches
- ☐ Chronic Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Passing Out
- ☐ Seizure / Epilepsy
- ☐ Stroke

Musculoskeletal

- ☐ Joint Pain
- ☐ Swelling in Extremities
- ☐ Back Pain
- ☐ Pain in Legs
- ☐ Leg Ulcers
- ☐ Varicose Veins
- ☐ Leg Cramps

Psychological

- ☐ Depression
- ☐ Anxiety
- ☐ Shaking
- ☐ Emotional Upsets
- ☐ Ever received psychiatric/psychological treatment?

Gynecologic / Other

- ☐ Breast Pain
- ☐ Breast Lumps
- ☐ Breast Discharge
- ☐ Menopause
- ☐ Irregular Cycle
- ☐ Last Cycle _____

PLEASE LIST ALL THE DIET PROGRAMS YOU HAVE USED IN THE PAST

Program	*When and How Long?*	*Total Weight Lost?*	*Pounds Regained?*

- ☐ Phentermine _____
- ☐ Phen-Fen, Redux _____
- ☐ Meridia _____
- ☐ Other (Weight Watchers, Atkins, etc.) _____
  _____

List **ALL** prescriptions and over-the-counter medications presently using _____
_____

List **ALL** prior surgeries and dates _____

List **ALL DRUG** allergies _____

Do you exercise?	What kind?				How much?	
Do you:	☐ eat breakfast?	☐ eat lunch?	☐ eat dinner?	☐ eat between meals?	☐ eat at night?	☐ eat when stressed?
Do you take:	☐ vitamins?	☐ laxatives?	☐ hormones?	☐ pain medication?	☐ stomach medication?	☐ birth control pills?
☐ nerve medication?	☐ cold medication?	☐ herbal supplements? *(name)*				
Do you smoke?	How much?	Do you use caffeine?	How much?	Do you drink alcohol?	How much?	

In the past year, have there been any changes in your family? *(Check all that apply)*
☐ Marriage ☐ Separation ☐ Divorce ☐ Loss of Job ☐ Birth ☐ Serious Illness ☐ Death ☐ Other

PATIENT'S SIGNATURE	**PHYSICIAN'S SIGNATURE**

Your signature indicates that the above information is complete and true. Physician will sign after reviewing with patient