Patient Medical History

Today's Date: ____________________

Patient's Last Name:	First:	Middle:	Preferred Name:

Date of Birth:	Height:	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	Head / Ears / Nose / Throat	Pulmonary	
☐ Unplanned Weight Change	☐ Visual Problems	☐ Cough	☐ Fall Asleep at Wheel
☐ Fevers	☐ Glasses / Contacts	☐ Wheezing	☐ Asthma
☐ Chills	☐ Cataracts	☐ Shortness of Breath	☐ Never Feel Rested
☐ Sweats	☐ Hearing Problems	☐ Positive TB Test	☐ Sleep Study Done
☐ Loss of Energy	☐ Sore Throat	☐ Snoring	Results: ____________
☐ Fatigue	☐ Sinus Infection	☐ Headache upon Waking	☐ Insomnia

Cardiac	Gastrointestinal		Genitourinary	Metabolic
☐ Chest Pain with Exertion	☐ Abdominal Pain	☐ Diarrhea	☐ Blood in Urine	☐ High Blood Pressure
☐ Chest Pressure	☐ Trouble Swallowing	☐ Constipation	☐ Hesitancy	☐ Diabetes
☐ Irregular Heart Beat	☐ Nausea	☐ Bright Red Blood in Stool	☐ Kidney Stones	☐ High Cholesterol
☐ Palpitations	☐ Vomiting	☐ Hemorrhoids	☐ Frequent Urination	☐ Thyroid Problems
☐ Congestive Heart Failure	☐ Dark / Black Stool	☐ Stomach Ulcers	☐ Prostate Problems	☐ Other ________
☐ Rheumatic Fever	☐ Yellow Jaundiced	☐ Heartburn or Reflux	☐ Discomfort-Urination	____________

Hematological	Neurological	Musculoskeletal	Psychological	Gynecologic / Other
☐ Abnormal Bleeding	☐ Severe Headaches	☐ Joint Pain	☐ Depression	☐ Breast Pain
☐ Easy Bruising	☐ Chronic Headaches	☐ Swelling in Extremities	☐ Anxiety	☐ Breast Lumps
☐ Blood Clots in Legs/Lungs	☐ Migraines	☐ Back Pain	☐ Shaking	☐ Breast Discharge
☐ HIV, AIDS	☐ Dizziness	☐ Pain in Legs	☐ Emotional Upsets	☐ Menopause
☐ Nose Bleeds	☐ Passing Out	☐ Leg Ulcers	☐ Ever received psychiatric/psychological treatment?	☐ Irregular Cycle
☐ Hepatitis B	☐ Seizure / Epilepsy	☐ Varicose Veins		☐ Last Cycle _____
☐ Hepatitis C	☐ Stroke	☐ Leg Cramps		

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

List **ALL** prior surgeries and dates ______________________________

List **ALL DRUG** allergies ______________________________

Family Medical History (*please check all that apply*)

☐ Heart Disease/Stroke	☐ Diabetes
☐ High Cholesterol	☐ Obesity
☐ High Blood Pressure	☐ Other

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

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

☐ Phentermine/Adipex______________________________
☐ Phen-Fen, Redux______________________________
☐ Meridia______________________________
☐ Other (Weight Watchers, Atkins, etc.)______________________________

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