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	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	☐ Irregular Cycle
☐ Hepatitis B	☐ Seizure / Epilepsy	☐ Varicose Veins	psychiatric/psychological	☐ Last Cycle _____
☐ Hepatitis C	☐ Stroke	☐ Leg Cramps	treatment?	

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