# New Patient Medical History Form

Name: (Last)_____ (First)_____

Date of Birth: _____ Gender: Male/Female

Contact Number: _____

Address:

_____

_____

Emergency Contact:

_____

_____

**Weight History**

**When did you become overweight?**

Childhood Teens Adulthood Pregnancy Menopause

**Have you ever gained more than 20 pounds within three months?** Yes/No

**How much did you weigh one year ago? _____ Five years ago? _____ Ten? _____**

**Circle any triggers for your weight gain:**

Stress Marriage Divorce Illness Medication abuse Travel

Injury/Surgery Work Insomnia Quitting smoking/alcohol

**Circle any previous weight-loss programs you have tried:**

Weight Watchers Nutrisystem Medifast Jenny Craig Atkins

South Beach Diet Paleo Ketogenic Diet HCG

**Circle any medications you have taken to lose weight:**

Phentermine/Adipex Meridia Xenical/Alli Phen-Fen Topamax

Bontril Saxenda Bupropion/Wellbutrin Belviq Qsymia

Contrave

**Number of times you eat per day: _____**

**Circle any food triggers:**

Stress Boredom Anger Reward seeking Parties

Eating Out Fast food Sugar Carbs Salt

**How many days per week do you workout? _____ Duration: _____**

**What kinds of workouts do you enjoy?**

Cardio Weights Classes Bootcamp Swimming

Other: _____

**What prevents you from working out?**

_____

_____

**Social History**

**Smoking:**

Never Current Past Smoker Social

**Alcohol:**

Never Occasional Daily Quit

**Drugs:**

Never Occasional Past/Quit Current Type of drugs: _____

**Medical History**

**Past Medical History (Circle any that apply)**

| | | | | |
|---|---|---|---|---|
| Heart attack | Angina | High blood pressure | Gallbladder stones | Sleep Apnea |
| Stroke | Hypothyroid | Hyperthyroid | Reflux/GERD | Gout |
| Diabetes | Cancer | High Cholesterol | Celiac Disease | Pancreatitis |
| PCOS | Infertility | | | |

**List any past surgical history:**

_____

_____

_____

**Current Medications (Including over-the-counter/vitamins/supplements)**

_____

_____

_____

**Allergies:** _____

**Family History (Circle all that apply)**

| | | | | |
|---|---|---|---|---|
| Obesity | Heart disease | Stroke | High blood pressure | Thyroid issues |
| Anxiety | Depression | Diabetes | High Cholesterol | Breast cancer |
| Colon cancer | | | | |

**Review of Systems (Circle all that apply)**

**General**

Fatigue Fever Weakness Weight Gain/loss Trouble sleeping

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**Skin**

Rashes Lumps Itching Dryness Color changes

Hair and nail changes

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**Head**

Headache Head Injury

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**Ears**

Ringing Decreased Hearing Drainage Earache

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**Eyes**

Blurry vision Cataracts Glaucoma Glasses/contacts Pain

Drainage Redness Itching Flashing lights

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**Nose**

Itching Nosebleeds Stuffiness Discharge Sinus pain

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**Throat**

Dry mouth Bleeding gums Dentures Sore throat Hoarseness

Ulcers Thrush

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**Neck**

Lumps Pain Stiffness Swollen glands

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**Breasts**

Lumps Discharge Pain Breast feeding Self-exams

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**Respiratory**

| | | | |
|---|---|---|---|
| Cough | Shortness of Breath | Wheezing | Sputum |

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**Cardiovascular**

| | | | |
|---|---|---|---|
| Chest Pain | Palpitations | Difficulty Breathing | Swelling/edema |

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**Gastrointestinal**

| | | | |
|---|---|---|---|
| Heartburn | Nausea/Vomiting | Diarrhea | Constipation |
| Jaundice | Rectal bleeding | | |

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**Urinary**

| | | | |
|---|---|---|---|
| Frequency | Burning | Incontinence | Blood in urine |

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**Genital**

| | | | |
|---|---|---|---|
| Pain with sex | Discharge | Erectile Dysfunction | Sores |
| Itching | Vaginal Dryness | | |

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**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint Pain | Stiffness | Back Pain | Trauma |

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**Neurologic**

| | | | |
|---|---|---|---|
| Seizures | Dizziness | Fainting | Numbness/Tingling |
| Weakness | | | |

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**Psychiatric**

| | | | |
|---|---|---|---|
| Nervousness | Depression | Memory Loss | Stress |