Patient Past Medical History

Patient Name: _____ DOB: _____ Age: _____

Weight History

Your present weight: _____ your weight goal: _____ height: _____

When did you first become overweight? (your age then) _____ (year) _____

How did your weight gain start? Describe any circumstances: _____

_____

What do you think is the cause of your weight problem _____

_____

Does your weight make you physically uncomfortable? _____ Limit your activities? _____

What was your highest weight? (excluding pregnancy) _____ (your age then) _____ # of years ago: _____

What was your lowest weight? _____ (your age then) _____ # of years ago: _____

Have you ever stayed the same weight for 10 years or more? YES/NO

Have you attempted to lose weight before? YES/NO Most lbs lost: _____ How long it took: _____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture) and describe your results: _____

_____

How many times per year have do you diet? _____ How many times have you failed at weightloss? _____

Do you have uncontrollable cravings? _____

When do you do most of your overeating? _____

Is successful weight loss a top priority? YES/NO Does your family serve as weight loss supporters? YES/NO

Please make any comments that you think might be helpful: _____

_____

Lifestyle History

1. Are you currently under the care of a physician? YES/NO
If YES, please explain? _____
2. Do you feel stressed? Explain _____
3. How many hours of sleep do you get each night? _____
4. Do you snore while you sleep? YES/NO _____ Have you been diagnosed with sleep apnea? YES/NO
5. Do you get angry often? YES/NO
6. Are you happy? If not, explain _____
7. What worries you most? _____
8. Is your health important to you? Yes/No Most important reason to be healthy? _____
9. Who makes decisions regarding your health? _____
10. Do you currently have any medical concerns? Please List: _____

_____

Past History: (Please check if you have had any of the following):

☐ Allergies to medicines, foods_____ ☐ Birth defects or abnormalities
☐ Exposed to tuberculosis ☐ Rheumatic Fever ☐ Scarlet Fever ☐ Polio
☐ Diabetes: Type: _____
☐ Cancer, Type:_____
☐ Heart Disease:_____
☐ High blood pressure:_____
☐ Asthma or Lung disease:_____
☐ Thyroid Dysfunction:_____
☐ Polycystic Ovarian Syndrome:_____
☐ Cushing Disease or other endocrine diseases:_____
☐ Psychiatric Disorders (e.g. depression, anxiety, anorexia, bulimia):_____
☐ Other Diseases _____
☐ Operations: (dates) _____

Current Medications: (vitamins, birth control pills): _____
_____
_____
_____
_____

Menstrual History:

Date of last menstrual period _____Menstruation began at age:_____
Duration of bleeding:_____Pain with periods?_____
Amount of flow : Light _____ Med. _____Heavy _____
Bleeding between periods:_____Bleeding after intercourse:_____
Irritation or discharge:_____Itching or burning _____
Are you on birth control? (method): _____
Is there any chance you may currently be pregnant?_____

Family History:

Father: Health _____ Current Age _____ Deceased _____ at age _____ Cause _____
Mother: Health _____ Current Age _____ Deceased _____ at age _____ Cause _____
_____
# of siblings:_____ # living_____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

☐ High blood pressure	☐ Heart trouble	☐ Anemia	☐ Obesity
☐ Migraine	☐ Bleeding (abnormal)	☐ Epilepsy	☐ Other _____
☐ Strokes	☐ Cancer	☐ Diabetes	
☐ Kidney disease	☐ Syphilis or (bad blood)	☐ Suicide	

Social History:

Single or married?_____Children?_____
Occupation?_____
Have you or do you currently smoke? _____ How much?_____ How many years: _____
Have you or do you currently drink alcohol?_____ Participate in illicit drug use?_____
Exercise/Hobbies?_____

Do you now have or have had any of the following?

☐ Trouble sleeping
☐ Fevers/chills/sweats
☐ Fatigue/malaise/Tire easily
☐ Rashes/itching
☐ Dry skin, Acne
☐ Hair loss, excessive hair growth
☐ Headaches
☐ Dizziness
☐ Syncope/fainting
☐ Visual changes
☐ Hearing changes
☐ Difficulty swallowing
☐ Pain or stiffness (neck)
☐ Swollen, enlarged glands (neck)
☐ Cough/Sputum Production
☐ Shortness of Breath
☐ Lung disease
☐ Chest pain
☐ Palpitation or fluttering
☐ Previous MI
☐ Swelling of ankles/legs
☐ Leg pains with walking
☐ Varicose veins
☐ Abdominal pain
☐ Nausea or vomiting
☐ Gas or bloating
☐ Diarrhea or constipation
☐ Change in appetite
☐ Bleeding or black stools
☐ Hernia
☐ Indigestion or heartburn
☐ Colitis
☐ Jaundice
☐ Gallstones
☐ Gastric ulcers
☐ Kidney stones
☐ Pus or blood in urine
☐ Bladder disease
☐ Painful urination
☐ Urgency, hesitancy with urinating
☐ Incontinence
☐ Low back pain
☐ Irregular periods
☐ Infertility
☐ Joint pains/Stiffness
☐ Numbness/tingling
☐ Weakness/paralysis
☐ Sadness/nervousness
☐ Mood changes
☐ Suicidal thoughts/actions
☐ Memory change
☐ Tremors
☐ Hot or cold intolerance
☐ Easy bruising
☐ Excessive bleeding
☐ Change in libido

Examinations:

Date of last physical examination: _____ Reason:_____
Date of last laboratory tests:_____
Hospitalizations _____ Dates _____ Reason:_____
X-Rays: Chest _____ Date_____ Other_____
Electrocardiogram (heart tracing) _____ Date of last pap _____

Financial Policy:

Thank you for selecting Dr. Shah, MD/Jennifer Mills, PA-C for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____
Patient's Signature Date

All Statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein. If I willingly withhold knowledge from my treating physician, I accept full liability from any consequences arising there from.

_____ _____
Patient's Signature Date