MD Weight Loss
3711 Garth Rd. Suite 160 Baytown, TX 77521
Office: 281.201.8243 Fax: 281.836.4708
www.mdweightlosscenter.com

Patient Medical History Form

Name: _____ Age: _____ Sex: M F

What is the purpose of your visit today?

_____

_____

Please list all your medications and dosage, including over-the-counter meds and vitamins:

_____ _____

_____ _____

Please list any allergies to food or medications:

_____ _____

_____ _____

Past Medical History (check all that apply)

[ ] High Blood Pressure
[ ] Diabetes
[ ] High Cholesterol
[ ] Heart Attack
[ ] Heart Arrhythmia
[ ] Congestive Heart Failure
[ ] Stroke / TIA
[ ] Cancer, Type: _____
[ ] Asthma
[ ] Emphysema
[ ] Obstructive Sleep Apnea
[ ] Peptic Ulcer Disease
[ ] Gastro esophageal Reflux
[ ] Diverticulosis
[ ] Colon Polyps
[ ] Kidney Stones
[ ] Kidney Disease
[ ] Gout
[ ] Depression
[ ] Thyroid Disease
[ ] Other _____

Are you currently taking any blood thinning medications? [ ] yes [ ] no

If yes, please list the medications and the conditions for which they are prescribed:

_____

Are you currently using a CPAP machine? [ ] yes [ ] no

Past Surgical History

_____ _____

_____ _____

Family History

Has any blood relative ever had any of the following?

High Blood Pressure	[ ] Yes	[ ] No	
Diabetes	[ ] Yes	[ ] No	
High Cholesterol	[ ] Yes	[ ] No	
Heart Attack	[ ] Yes	[ ] No	
Stroke	[ ] Yes	[ ] No	
Cancer	[ ] Yes	[ ] No	If yes, what type? _____
Psychiatric Disorder	[ ] Yes	[ ] No	If yes, what type? _____

Social History

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widow(er)

Occupation: _____

Habits	Heavy	Moderate	Light	None
Alcohol	[ ]	[ ]	[ ]	[ ]
Coffee	[ ]	[ ]	[ ]	[ ]
Tobacco	[ ]	[ ]	[ ]	[ ]
Sleep	[ ]	[ ]	[ ]	[ ]

Have you ever been hospitalized or been under medical care for any psychiatric illness, alcohol or drug rehab? [ ] yes [ ] no

If yes, please explain: _____

For women only

Are you currently pregnant or breast feeding? [ ] yes [ ] no

Are you currently using birth control pills? [ ] yes [ ] no

What was the first date of your last period? _____

Are your periods regular? [ ] yes [ ] no

If no, please explain: _____

Nutritional Evaluation

Present Weight: _____ Weight one year ago: _____ Desired Weight: _____

Height (without shoes): _____ Current Clothing Size: _____ Desired Clothing Size: _____

How fast do you want to lose the weight? _____

What is the main reason why you want to lose weight? _____

Who encouraged you to lose weight? _____

Do your family and friends support your weight loss efforts? [ ] yes [ ] no

Do you feel you eat because of emotions? [ ] yes [ ] no

If yes, please explain: _____

What weight loss program(s) have you tried in the past, and what were the results?

_____

_____

Food Allergies: _____ Food Cravings: _____

Food Dislikes: _____

Do you eat fast foods? [ ] yes [ ] no

If yes, how often? _____

What are your worst food habits? _____

What do you normally eat for:

Breakfast?	Lunch?	Snack?	Dinner?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is most important to you in deciding to enroll into you program? (please check all that apply)

[ ] Effectiveness
"My results are top priority"

[ ] Time
"I want results quickly"

[ ] Service
"I want help when I need it"

[ ] Ease
"I have a difficult time losing weight"

Review of Systems

Please check the items that apply.

Head and Neck
[ ] Eye pain
[ ] Eye drainage
[ ] Hearing loss
[ ] Ear pain
[ ] Ear drainage
[ ] Ringing in ears
[ ] Sinus pain or pressure
[ ] Allergies
[ ] Nasal congestion
[ ] Sore Throat
[ ] Runny nose
[ ] Sneezing
[ ] Frequent nosebleeds
[ ] Bleeding gums
[ ] Dental problems
[ ] Sores in mouth
[ ] Hoarseness
[ ] Swelling in neck

Energy
[ ] Fatigue
[ ] Heat or cold intolerance
[ ] Generalized weakness
[ ] Lethargy
[ ] Restlessness
[ ] Hyperactivity

Cardiac
[ ] Chest pain or pressure
[ ] Racing heartbeat
[ ] Palpitations
[ ] Swelling of ankles

Pulmonary
[ ] Waking up at night short of breath
[ ] Daytime sleepiness
[ ] Snoring
[ ] Stop breathing during sleep
[ ] Short of breath when lying flat
[ ] Shortness of breath
[ ] Wheezing
[ ] Persistent cough
[ ] Coughing up blood

Digestive
[ ] Abdominal pain
[ ] Nausea/vomiting
[ ] Heartburn
[ ] Vomiting blood
[ ] Pain with swallowing
[ ] Difficulty swallowing
[ ] Blood in stool
[ ] Black bowel movements
[ ] Constipation
[ ] Diarrhea

Skin
[ ] Skin rash
[ ] Dry skin
[ ] Changing mole
[ ] Joint pain or swelling
[ ] Skin ulcer or non-healing sore
[ ] Lumps or bumps
[ ] Excessive sweating

Emotional & Mental
[ ] Anxiety
[ ] Depression
[ ] Impaired sexual function
[ ] Mood swings
[ ] Irritability
[ ] Poor Concentration

Genital Urinary
[ ] Burning with urination
[ ] Excessive urination
[ ] Incontinence of urine
[ ] Urinary urgency
[ ] Urinary frequency
[ ] Getting up to urinate at night
[ ] Weakened urine stream
[ ] Blood in urine

Neurological
[ ] Numbness or tingling
[ ] Slurred speech
[ ] Loss of consciousness
[ ] Loss of vision
[ ] Loss of balance
[ ] Seizures
[ ] Double vision
[ ] Paralysis
[ ] Tremor
[ ] Severe headaches
[ ] Dizziness

Other Symptoms
[ ] Unexplained weight loss/gain
[ ] Trouble sleeping
[ ] Excessive thirst
[ ] Fever and chills

My signature below warrants that I have completed this questionnaire truthfully and accurately. My records will be kept confidential and will only be shared with staff. My written consent is required for any sharing of information outside of Medical Weight Loss and Wellness.

Print Name: _____

Signature: _____ Date: _____