Patient Name: _____ DOB_____ Date_____

Dr. McGee and staff review all information carefully. Your entire history is important to us.

MEDICAL HISTORY

Please check all that apply:

_____High Blood Pressure
_____Chest Pain
_____Edema (Swelling of Legs)
_____Congestive Heart Failure
_____Previous Stroke or Heart Attack
_____Varicose veins or Venous Stasis
_____DVT or Pulmonary Embolus
_____Shortness of Breath
_____Snore
_____Daytime drowsiness
_____Sleep Apnea
_____Use CPAP or BIPAP
_____Asthma
_____Emphysema
_____COPD
_____Use of Home Oxygen
_____Diabetes – Juvenile
_____Diabetes – Adult Onset
_____Diabetes – Pregnancy
_____Always Thirsty
_____Cold Intolerance
_____Underactive Thyroid
_____Overactive Thyroid
_____Significant Hair Loss
_____ Pituitary Gland Disease
_____Adrenal Gland Disease
_____Kidney Disease
_____Gout
_____High Triglycerides
_____High Cholesterol
_____Gallbladder diseases
_____Heart Burn/Reflux/GERD
_____Chronic Constipation
_____Chronic Diarrhea

_____ Irritable Bowel Syndrome
_____History of Colon Cancer
_____Hernias
_____Urinary Incontinence
_____Trouble Urination/ Male BPH
_____Frequent Urination
_____History of Prostate Cancer
_____Sexual Dysfunction/Low Sex Drive
_____Chronic Fatigue
_____Eats Ice Frequently (PICA)
_____Excess Facial Hair (Female)
_____Abnormal Menstrual Cycle
_____Difficulty becoming pregnant
_____Polycystic Ovarian Syndrome
_____History of Breast Cancer
_____History of Ovarian or Uterine Cancer
_____Hot Flashes/Night Sweats
_____Trouble Falling Asleep
_____Trouble Staying Asleep
_____Depression - New Onset
_____Depression – Chronic
_____Bipolar Disease
_____Anxiety or High Stress
_____Migraine Headaches
_____Binge Eating
_____Bulimia or Purging
_____Anorexia Nervosa
_____Restless Leg Syndrome
_____Arthritis/Osteoarthritis
_____Lower Back Pain
_____Need Assistance Walking
_____Numbness in Hands/Feet

Any other medical or psychiatric problems not listed:

_____

Patient Name: _____ DOB_____ Date_____

MEDICATIONS

List all of medications you currently take including vitamins, minerals and herbs, hormones, birth control pills.

1._____
6._____
2._____
7._____
3._____
8._____
4._____
9._____
5._____
10._____

ALLERGIES

Do you have any medical or food allergies?

_____

PERSONAL PHYSICIAN

Do you have a primary care physician or an Internal Medicine doctor? Yes □ No □
Primary Care Doctor's Name _____
City Located_____

PAST SURGICAL HISTORY

Previous Surgeries: 1._____
4._____
2._____
5._____
3._____
6._____

OB/GYN HISTORY

Do you still have periods? Yes □ No □
Have you had a Hysterectomy or tubal ligation? Yes □ No □
Do you have regular monthly menstrual periods? Yes □ No □
If no,
explain:_____
_____
Are your periods heavy? Yes □ No □
How many days do your periods last? _____
Are you past menopause? Yes □ No □
History of Miscarriages Yes □ No □ Ectopic Pregnancies Yes □ No □ Birth Control Yes □ No □

FAMILY HISTORY

□ Obesity □ High Cholesterol □ Diabetes
□ Lung Disease/asthma/emphysema □ High blood pressure □ Kidney disease □ Heart Disease/stroke □ Bleeding disorder □ Cancer
□ Psychiatric (depression, eating disorder, alcoholism)

Patient Name: _____ DOB_____ Date_____

SOCIAL HISTORY

Married □ Single □ Divorced □ Widowed □
Number of children or grandchildren living with you? _____ Ages:
_____
Have you ever smoked cigarettes? Yes □ No □ Amount: _____
If you have quit smoking, when did you stop?
_____
History of drug abuse? Yes □ No □ Treatment? Yes □ No □
History of alcohol abuse? Yes □ No □ Treatment? Yes □ No □
How many hours do you typically sleep per night?_____
Occupation: _____ Working Hours:_____
Are you a student? Yes □ No □ If so, full time □ part time □
Typical time you wake up _____ Typical time you go to bed: _____
Do you work overnight shift? Yes □ No □
What time do you wake up & go to sleep when working overnight? _____

WEIGHT HISTORY

What is your high school graduation weight (age 18) _____
Marriage Weight _____ Desired Weight_____
When did you begin gaining excessive weight?
_____

DIET HISTORY

Do you eat 3 meals/day? Yes □ No □ If not, how many? _____
Which meals do you commonly miss?
_____
Do you graze throughout the day? Yes □ No □
How many times do you eat out or pick something up to bring home? _____
Are you a night time eater? Yes □ No □
If so what do you normally eat?
_____
Are you a binge eater? Yes □ No □
History of purging after you binge? Yes □ No □
If yes, are you purging through exercise, vomiting, laxatives, or diuretics?
_____
Do **you** do the majority of the grocery shopping? Yes □ No □

Patient Name: _____ DOB_____ Date_____
Do **you** cook at home? Yes □ No □
Do you or other people think you eat too fast? Yes □ No □
Is your spouse, fiancée or partner overweight? Yes □ No □
Do you have any overweight children? Yes □ No □
If you are a vegetarian, what foods will you not eat?_____
Have you used weight loss medications in the past? Yes □ No □ If yes name:_____
If you have taken weight loss medication in the past, how long ago did you take it?_____
If you have taken weight loss medication did you experience side effects? Yes □ No □
If yes, please explain_____
If you have taken weight loss medication in the past, how much weight did you lose?_____

DO YOU DRINK:

Sweet Tea made with **sugar**? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Regular soft drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Fruit Juices? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Hawaiian Punch? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Kool Aid? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Energy Drinks? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Whole Milk? Yes □ No □ If yes, □ Daily □ Few per week □ rarely
Alcohol? Yes □ No □ If yes, □ Daily □ Few per week □ Special Occasions
If yes, what type of alcohol do you drink?

_____

Your diet history will be discussed during your initial visit. All efforts are relevant, even those with minimal or no weight loss. Please list all significant diet efforts for the past 5 years.

Name of Diet	Year	Length of Effort	Weight Loss	Weight Regained
1.				
2.				
3.				
4.				