NEW PATIENT INTAKE/MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

Home address:_____

Insurance information:
Name:_____ Plan name/type:_____

Insurance ID:_____ Group ID:_____

Effective from: _____ Relation to insured: _____

How does your weight affect your life and health? _____
_____
_____

Preferred pharmacy:

Name: _____ Address: _____

Pharmacy phone number: _____

Weight History

When did you become overweight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: _____
What worked? _____
What didn't work? _____
Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____
Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____
Eating triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _____

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: _____

Medical History

Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____

How many hours do you sleep per night? _____ How times do you get up during the night? _____
Do you feel rested in the morning? _____

Past medical history (check all that apply):
☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux arthritis ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Polycystic Ovarian Syndrome
☐ Cancer (type/s): _____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications and dosages):

_____ _____ _____ _____
_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son
Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol
☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____
Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)
☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds

☐ Acne	☐ Skin rash	☐ Cough
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Loss of urine control	☐ Blood in stools
☐ Back pain (upper)	☐ Back pain (lower)	☐ Joint pain
☐ Muscle aches/pain	☐ Dizziness	☐ Headaches

☐ Seizures
☐ Depression
☐ Inability to concentrate
☐ Loss of interest
☐ Hair changes
☐ Fatigue/tiredness
☐ Weakness/low energy
☐ Insomnia
☐ Mood changes
☐ Cold intolerance
☐ Heat intolerance
☐ Anxiety
☐ Memory loss
☐ Nervousness
☐ Excessive sweating
☐ Blood clots

(Men only)

☐ Difficulty with erections
☐ Loss of interest in sex
☐ Low testosterone

(Women only)

☐ Absence of periods
☐ Abnormal/excessive menstruation
☐ Difficulty getting pregnant
☐ Hot flashes
☐ Facial hair
☐ Change in bladder habits
☐ Loss of interest in sex

Comments: _____