**COMPREHENSIVE 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: NOTE: If previously provided, do not have to complete again.

Name:_____ Plan name/type:_____

Insurance ID:_____ Group ID:_____

Effective from: _____ Relation to insured: _____

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

What is your goal for your weight?_____

Preferred pharmacy: NOTE: If previously provided, do not have to complete again.

Name: _____ Address: _____

Pharmacy phone number: _____

**Weight History:** NOTE: You may skip this section if you completed an Intake Consultation previously.

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 currently? _____
_____

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 _____

Number of times ordering in/eating out per week: _____

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: _____

**Lifestyle History:**

Do you travel for work? Y / N _____

Who does the grocery shopping and food prep in your home? _____

Do you face barriers to cooking at home? Y / N If so, what:_____

**Exercise**:
Typical types you enjoy:_____

Duration: _____ hours _____ minutes Number of times per week: ____

What prevents you from exercising? _____

**Sleep:**
How many hours do you sleep per night? _____
How many times do you get up during the night? _____
Do you feel rested in the morning? Y / N
Do you snore? Y / N
Have you ever been tested for sleep apnea? Y / N Any details: _____

**Detailed Medical Assessment:**
**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: _____

Any history of the following?:

Kidney stones: Y / N
Gestational diabetes: Y / N N/A
Heart testing: Y / N
Seizures: Y / N
Thyroid problems: Y / N

Medications (list all current medications and dosages):

_____ _____ _____ _____
_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

**<u>Social History</u>**
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 | ☐ Weakness/low energy | ☐ Anxiety |
| ☐ Depression | ☐ Insomnia | ☐ Memory loss |
| ☐ Inability to concentrate | ☐ Mood changes | ☐ Nervousness |
| ☐ Loss of interest | ☐ Cold intolerance | ☐ Excessive sweating |
| ☐ Hair changes | ☐ Heat intolerance | ☐ Blood clots |
| ☐ Fatigue/tiredness | | |

**(Men only)**

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

**(Women only)**

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

Comments: _____