Medical History Questionnaire

Name _____ **Date of Birth** _____

Weight Loss/Diet History:

Weight 1 year ago		Weight 5 years ago	
Weight 2 years ago		Weight at age 18	
Weight 3 years ago		Heaviest weight you have ever been	
Weight 4 years ago		How long have you been overweight?	

What do you feel your weight (obesity) is due to? _____

_____

Diet	How long?	Weight lost	Reason stopped
Alli			
Atkins			
Diabetes education			
Exercise			
Help from family dr			
LA Weight Loss			
Low Calorie			
Low Fat			
Meridia			
Metabolife			
Nutrition counseling			
Phen-Fen			
Slim Fast			
TOPs			
Weight Watchers			
Xenical			
Other:			

Do you exercise now? ☐Yes ☐ No

What do you do?_____

How often?_____

Do you: ☐ Need a cane/walker to walk 200 ft? ☐ Need a wheelchair?

☐ Can not walk 200 ft with cane/walker

Please check all that apply?

☐ I tend to eat out/take out at least twice per week

☐ I tend to eat in binges, especially when I feel stressed or depressed.

☐ I always clean my plate and have trouble stopping once I begin eating

☐ I tend to have second helpings

What food(s) do you have trouble avoiding?

☐ Sweets ☐ Regular soda ☐ Chips/ snack foods

☐ Pasta ☐ Regular Iced Tea ☐ Alcohol

☐ Ice cream ☐ Fatty meats

☐ Breads ☐ Fried Foods

Provider signature _____ Date _____

Name _____ **Date of Birth** _____

Check all that apply.

Last physical exam _____

General:	□ Fever	□ Chills	□Fatigue
Head/Neck:			
□ Glasses / contacts	□ Hearing loss / aids	□ Neck lumps/bumps	□ Migraine type headache
□ Visual changes	□ Neck pain	□ Allergies / hay fever	
□ Glaucoma	□ Hoarseness	□ Daily headaches	
Lungs:			
□ Sleep apnea	□ Difficulty sleeping	□ Daytime sleepiness	□ Cough with mucous
□ Use CPAP	□ Snoring	□ Breathing problems	□ Short of breath
□ Asthma (wheezing)	□ Tuberculosis	□ Cough	□ Nose bleeds
Heart:			
□ High blood pressure	□ Had stress test for heart	□ Swelling in legs	□ Heart murmur
□ Heart attack (MI)	□ Had heart cath	□ Blood clots	□ Irregular heart beat
□ Stroke	□ Poor circulation	□ Chest pain, when walking	□ Heart palpitations
□ Heart failure		□ Chest pain, at rest	
□ High cholesterol			
Gastrointestinal:			
□ Jaundice (Liver disease)	□ Hepatitis – type ____	□ Difficulty swallowing	□ Constipation
□ GERD (reflux/heartburn)	□ Gallstones	□ Abdominal pain	□ Diarrhea (irritable bowel)
	□ Gallbladder removed	□ Vomiting	□ Change in bowel habits
	□ Hiatal Hernia	□ Black stools	
Genital / Urinary:			
□ Bladder control problem	□ Kidney disease	□ Erectile dysfunction	□ Slow urine stream
	□ Burning with urination	□ Blood in urine	
Endocrine:			
□ Diabetes (high blood sugar)	□ Thyroid disease	□ Excessive thirst	□ Osteoporosis
		□ Hot flashes	□ Easy bruising
Women only:			
□ Last mammogram___	□ Poly cystic ovary disease	□ Date of last menstrual period _____	□ Heavy periods
□ Planning a future pregnancy	□ Facial hair	□ Last female exam___	□ Irregular periods
Musculoskeletal:			
□ Arthritis (joint paint)	□ Back pain	□ Fibromyalgia	□ Hernia -- where? _____
	□ Knee pain	□ Gout	
	□ Leg pain		
Skin:			
	□ Problem with excess skin	□ Skin rash	□ Rosacea
		□ Acne	□ Skin cancer
Neurological:			
□ Seizures	□ Weakness	□ Tremor	□ Fainting spells
	□ Numbness	□ Dizziness	
Other:	□ Cancer _____	□ HIV/AIDS	

Provider signature _____ Date _____

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List any allergies you have:

Allergy to:	Symptom

Current prescription medications you are taking:

Name	How often	Strength

Current vitamins, supplements or over-the-counter medicines you are taking:

Name	How often	Strength

Provider signature _____ Date _____

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List all previous hospitalization and surgeries

Type/Reason	Date	Hospital	Physician

Family History	Age/Age at Death	Ht / Wt	Medical Problems
Mother			
Father			
Brothers			
Sisters			
Children			

Does obesity run in your family? ☐Yes ☐ No

Psycho-social:

☐ Depression

☐ Mental Health problems --what? _____

☐ Alcohol -- how often? _____

☐ Have you ever used tobacco? _____ How long? _____

How much tobacco do you use? _____

☐ Have you ever used illicit drugs? _____ What? _____

Please circle the highest level of education you have <u>completed</u>:

Grade school

High School / GED

College: number of years completed _____

The above information is accurate and complete to the best of my knowledge:

Patient signature _____ Date _____

Provider signature _____ Date _____