



Patient Medical History

Today's Date: _____

| | | | | | | | |
|---|--|-------------|---------------------|-----------------|-----------------|----------------------------|-------------------------|
| Patient's Last Name: | | First: | | Middle: | | Preferred Name: | |
| Date of Birth: | | Height: | Age: | Sex: | Marital Status: | | Social Security # (opt) |
| Street Address: | | | | City and State: | | | Zip Code: |
| Home Phone: | | Cell Phone: | | | E-mail Address: | | |
| Occupation: | | Job Title: | | | How Long: | | Work Phone: |
| Employer: | | | Employer's Address: | | | | |
| Spouse's Name: | | | Spouse's Employer: | | | Spouse's Work Phone: | |
| Relative other than at your home address: | | | | Relationship: | | Phone Number: | |
| Children's Names and Ages: | | | | | | How did you hear about us? | |

PATIENT HISTORY *(please check all that apply)*

| General | Head / Ears / Nose / Throat | Pulmonary | |
|--|--|---|--|
| <input type="checkbox"/> Unplanned Weight Change <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Sweats <input type="checkbox"/> Loss of Energy <input type="checkbox"/> Fatigue | <input type="checkbox"/> Visual Problems <input type="checkbox"/> Glasses / Contacts <input type="checkbox"/> Cataracts <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Sore Throat <input type="checkbox"/> Sinus Infection | <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Positive TB Test <input type="checkbox"/> Snoring <input type="checkbox"/> Headache upon Waking | <input type="checkbox"/> Fall Asleep at Wheel <input type="checkbox"/> Asthma <input type="checkbox"/> Never Feel Rested <input type="checkbox"/> Sleep Study Done Results: _____ <input type="checkbox"/> Insomnia |

| Cardiac | Gastrointestinal | Genitourinary | Metabolic |
|---|--|---|---|
| <input type="checkbox"/> Chest Pain with Exertion <input type="checkbox"/> Chest Pressure <input type="checkbox"/> Irregular Heart Beat <input type="checkbox"/> Palpitations <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Dark / Black Stool <input type="checkbox"/> Yellow Jaundiced | <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bright Red Blood in Stool <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Heartburn or Reflux | <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Hesitancy <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Prostate Problems <input type="checkbox"/> Discomfort-Urination |

| Hematological | Neurological | Musculoskeletal | Psychological | Gynecologic / Other |
|--|---|---|---|---|
| <input type="checkbox"/> Abnormal Bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Blood Clots in Legs/Lungs <input type="checkbox"/> HIV, AIDS <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Severe Headaches <input type="checkbox"/> Chronic Headaches <input type="checkbox"/> Migraines <input type="checkbox"/> Dizziness <input type="checkbox"/> Passing Out <input type="checkbox"/> Seizure / Epilepsy <input type="checkbox"/> Stroke | <input type="checkbox"/> Joint Pain <input type="checkbox"/> Swelling in Extremities <input type="checkbox"/> Back Pain <input type="checkbox"/> Pain in Legs <input type="checkbox"/> Leg Ulcers <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Shaking <input type="checkbox"/> Emotional Upsets <input type="checkbox"/> Ever received psychiatric/psychological treatment? | <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breast Lumps <input type="checkbox"/> Breast Discharge <input type="checkbox"/> Menopause <input type="checkbox"/> Irregular Cycle <input type="checkbox"/> Last Cycle _____ |

List **ALL** prescriptions and over-the-counter medications presently using _____

List **ALL** prior surgeries and dates _____

List **ALL DRUG** allergies _____

Family Medical History *(please check all that apply)*

| | |
|---|-----------------------------------|
| <input type="checkbox"/> Heart Disease/Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other |

PLEASE LIST ALL THE DIET PROGRAMS YOU HAVE USED IN THE PAST

| Program | When and How Long? | Total Weight Lost? | Pounds Regained? |
|--|--------------------|--------------------|------------------|
| <input type="checkbox"/> Phentermine/Adipex | _____ | _____ | _____ |
| <input type="checkbox"/> Phen-Fen, Redux | _____ | _____ | _____ |
| <input type="checkbox"/> Meridia | _____ | _____ | _____ |
| <input type="checkbox"/> Other (Weight Watchers, Atkins, etc.) | _____ | _____ | _____ |

| | |
|----------------------------|------------------------------|
| PATIENT'S SIGNATURE | PHYSICIAN'S SIGNATURE |
|----------------------------|------------------------------|