

**Physician's Weight Control and Wellness Centers
PATIENT MEDICAL HISTORY**

Today's Date: _____

Patient's Last Name:		First:	Middle:	Preferred Name:	
Date of Birth:		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
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Other _____			

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 _____								

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 _____			
<input type="checkbox"/> Phen-Fen, Redux _____			
<input type="checkbox"/> Meridia _____			
<input type="checkbox"/> Other (Weight Watchers, Atkins, etc.) _____			

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

List **ALL** prior surgeries and dates _____

List **ALL DRUG** allergies _____

Do you exercise?		What kind?				How much?		
Do you:	<input type="checkbox"/> eat breakfast?	<input type="checkbox"/> eat lunch?	<input type="checkbox"/> eat dinner?	<input type="checkbox"/> eat between meals?	<input type="checkbox"/> eat at night?	<input type="checkbox"/> eat when stressed?		
Do you take:	<input type="checkbox"/> vitamins?	<input type="checkbox"/> laxatives?	<input type="checkbox"/> hormones?	<input type="checkbox"/> pain medication?	<input type="checkbox"/> stomach medication?	<input type="checkbox"/> birth control pills?		
<input type="checkbox"/> nerve medication?	<input type="checkbox"/> cold medication?	<input type="checkbox"/> herbal supplements? (name)						
Do you smoke?	How much?	Do you use caffeine?	How much?	Do you drink alcohol?	How much?			
In the past year, have there been any changes in your family? (Check all that apply)								
<input type="checkbox"/> Marriage	<input type="checkbox"/> Separation	<input type="checkbox"/> Divorce	<input type="checkbox"/> Loss of Job	<input type="checkbox"/> Birth	<input type="checkbox"/> Serious Illness	<input type="checkbox"/> Death	<input type="checkbox"/> Other	

PATIENT'S SIGNATURE	PHYSICIAN'S SIGNATURE
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Your signature indicates that the above information is complete and true. Physician will sign after reviewing with patient Revised 2/13/2008