

Medi-Weightloss Clinics® Patient History						Chart:	
<i>All questions contained in this history form are strictly confidential and will become part of your medical record on file.</i>						Office Use Only	
Last Name:	First Name:	Middle:	Gender:	Birth Date:	Age:		Date:
			<input type="checkbox"/> M <input type="checkbox"/> F	/ /			
Primary Physician/Referral:		Physician Phone Number:					Revisions:
		()					
Optometrist/Ophthalmologist:		Ophthalmologist Phone Number:				Weight:	
		()					
Last Physical:	Last EKG:	Last Eye Exam:			Goal Weight:		

Health History Complete to the best of your knowledge.

	Family	Personal		Family	Personal		Family	Personal
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Pulse	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>

Comments/Other:

Surgeries & Other Hospitalizations

Year	Reason / Diagnosis	Hospital

Medication Allergies

Medication Name	Reaction

Prescribed Medications & Over-the-Counter drugs, dietary supplements (including vitamins, inhalers, etc)			
Medication Name	Strength	Frequency	
Behavior Style			<i>Please select only one answer.</i>
<input type="checkbox"/>	You are always calm and easygoing.	<input type="checkbox"/>	You are usually calm and easygoing.
<input type="checkbox"/>	You are seldom calm and persistently driving for advancement	<input type="checkbox"/>	You are never calm and have overwhelming ambition
<input type="checkbox"/>		<input type="checkbox"/>	You are sometimes calm and easygoing
<input type="checkbox"/>		<input type="checkbox"/>	You are hard-driving and never relax.
Health Habits & Personal Safety			<i>This section is optional. All answers will be kept strictly confidential.</i>
Exercise	<input type="checkbox"/> Sedentary (no exercise)		
	<input type="checkbox"/> Mild Exercise (i.e., climbing stairs, walking three blocks, golf)		
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes)		
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4 times per week or more for 30 minutes or more)		
Diet	Are you dieting?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you on a physician-prescribed medical diet?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	How many meals do you eat in an average day?		
	Rank your salt intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
	Rank your fat intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low
Caffeine	Rank your caffeine intake:		<input type="checkbox"/> High <input type="checkbox"/> Medium <input type="checkbox"/> Low <input type="checkbox"/> None
	What types of caffeine do you drink?		<input type="checkbox"/> Coffee <input type="checkbox"/> Tea <input type="checkbox"/> Soda
	How many cups/cans per day?		
Alcohol	Do you drink alcohol?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, what kind?		<input type="checkbox"/> Beer <input type="checkbox"/> Liquor <input type="checkbox"/> Wine
	How many drinks per week?		
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – packs/day:	<input type="checkbox"/> Chew – #/day:	<input type="checkbox"/> Pipe – #/day:
	<input type="checkbox"/> Cigars – #/day:		
	How many years?		
Drugs	If you previously used tobacco, what year did you quit?		
	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever taken street drugs with a needle?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sex	Are you sexually active?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes, are you trying for a pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	If you are not trying for a pregnancy, what contraceptive methods are you using?		
Women Only			
How old were you at onset of menstruation?		Date of last menstruation?	
How often do you get your period (days)?		Number of Pregnancies:	Number of live births:
Heavy periods, irregularity, spotting, pain, or discharge?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you pregnant, trying for pregnancy, or breast feeding?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Weight History	
1.	What is the main reason you decided to lose weight?
2.	When did you begin gaining excess weight (give reasons if known)?
3.	What do you think is the main cause of your weight problems?
4.	Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5.	Is your spouse, fiancé, or partner overweight?
6.	How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7.	List any food allergies:
8.	What foods do you avoid?
9.	What foods do you crave?
10.	Do you awaken hungry during the night?
11.	What are your worst food habits?
12.	What are your snack habits?
13.	Rate your body from 1 to 10. How would you describe your body?
14.	If you could change one thing about your body, what would it be?
15.	What do you feel will be your obstacle(s) to successful weight loss?
16.	What is your typical breakfast? What time? Where? With whom?
17.	What is your typical lunch? What time? Where? With whom?
18.	What is your typical dinner? What time? Where? With whom?
19.	Add any additional comments you think would be helpful to the doctor.

Accuracy Agreement	
I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.	
Signature:	Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.