the center for medical weight loss®

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NEW PATIENT – MEDICAL HISTORY FORM

Today's Date: _____

Name:_____ **Date of Birth**_____

PAST MEDICAL HISTORY: Please mark Y(yes) or N(no) beside each.

Anxiety Disorder		Cancer:		Eating Disorder		High Cholesterol	
Arthritis		Depression		Heart Conditions		Hypertension	
Asthma		Diabetes		Heart Disease		Metabolic Syndrome	
Birth Defects or Inherited Diseases		Drug or Alcohol Abuse		High Blood Pressure		PCOS	

Age at start of weight gain_____ Other:_____

SURGICAL HISTORY: Please list ALL Surgeries and Dates

_____Date_____ _____Date_____

_____Date_____ _____Date_____

MEDICATIONS: List all medications you are currently taking, including over-the-counter medications, vitamins and herbal remedies, DOSAGE and FREQUENCY:

_____ _____ _____ _____

_____ _____ _____ _____

ALLERGIES: Please List ALL allergies or adverse reactions:

Medication and/or Food: **Reaction:**

_____ _____

_____ _____

Preferred Pharmacy:_____ **Location**:_____

Primary Care Physician:_____ **Location**:_____

FAMILY HISTORY: Please put a Y(yes) for Family History of mother, father.

ILLNESS	MOTHER	FATHER	ILLNESS	MOTHER	FATHER
Asthma			Hypertension		
Cancer – Colon			Stroke		
Cancer-Other			Thyroid Disease		
Cardiovascular (Heart) Disease			Overweight/Obese		
Diabetes			Other:		

SOCIAL HISTORY: Please fill out appropriately

Diet (ie: regular, Vegetarian, gluten free)		Appetite Suppressant - Name		Alcohol Intake - Number of drinks/week	
Number of Days/week you eat breakfast		Water intake 32 oz./day or more		Caffeine Intake (none, occasional, heavy)	
Exercise Level		Chest pains, Shortness of breath, Heart Palpitations with physical activity		Pacemaker	
General Stress Level		Past liquid diet(s) did you eat any food?		What time do you go usually go to bed?	
Live alone or with others (number)		Occupation		What time do you wake up?	
Number of Children		Occupation- Number of days/week		Who prepares meals?	
Obese		Time you get to work and time you get home		Who shops for groceries?	
Overweight		Exercise – Minutes/Day		Women – Pregnant or breastfeeding	
Smoker (how much)		Exercise – Days/Week		Year last at goal weight	
Previous Weight Loss Programs		Goal Weight		Screen time at home – TV, computer, etc.	
Currently taking Anti-Depressants		How often do you weigh yourself? Never, daily, weekly			

If you have previously tried weight loss program, what did you like about the program? and What didn't you like?

_____

If you have lost weight before what do you think prevents your weight loss/weight maintenance success?

_____

You have been offered $50,000 if you can do the following: Exercise for 45 minutes, 6 days per week for one year without changing any of your current responsibilities. When would you do the exercise and what would it be?

_____

Which of the following statements describes you best *(circle one)*:

1. I am highly motivated to lose weight and I will do whatever it takes to get healthy.
2. I definitely want to lose weight but I would rather go slow and steady.
3. I know weight loss is hard and I am not sure any program will work for me.

Which of the following statements describes you best *(circle one):*

1. I know exercise is **necessary** to lose and maintain weight loss, but there is no way I can fit it into my schedule.
2. I already exercise as much as I possibly can which is 1-3 times per week.
3. I currently exercise most days for more than 30 minutes.

_____I understand that the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I will report any changes in my medical condition to the office staff as soon as possible. The Center for Medical Weight Loss may notify your primary care physician if you enroll in a medical weight loss program. I have read the above questionnaire and acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omission I may have made in completion of this form.

_____ _____

Patient Signature Date