NEW PATIENT MEDICAL HISTORY FORM

Print Name: _______________________________ DOB: ____/____/_______ Date: ____/_____/________

How does your weight affect your life and health? ____

____

____

Weight History

When did you become overweight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _________

As best you can remember, how much did you weigh one year ago? _____

Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):

☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury

☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):

☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins

☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet

☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _______________________

What was your maximum weight loss? ____

What are your greatest challenges with dieting? ____

____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine(Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen

☐ Phendimetrazine(Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion

☐ Bupropion(Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave

Other: _______________________

What worked? ____

What didn't work? ____

Why or why not? ____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.

Number of times you eat per day: _____

Do you get up at night to eat? Y / N If so, how often? _____ times

Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out

☐ Fast Food ☐ Other: _______________________

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions

Favorite foods: ____

Medical History

Exercise type: ____

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising? ____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea

☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux arthritis ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Polycystic Ovarian Syndrome
☐ Cancer (type/s): ____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? ______________________

Past SURGICAL history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: ____

Medications (list all current medications and dosages): ____
____
____

Drug Allergies: ____
(Food)____

Social History
Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: ______________________
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History
Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Daughter ☐ Son
Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother
☐ Daughter ☐ Son
Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol
☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression
☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): ____
Other: ____

Gynecologic History
Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____

System Review (Check all that apply)
Age at first pregnancy: _____ Age at last pregnancy: _____
☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds
☐ Acne ☐ Skin rash ☐ Cough
☐ Snoring ☐ Shortness of breath ☐ Chest pain
☐ Difficulty breathing when flat ☐ Fainting/Blacking out ☐ Palpitations
☐ Swelling ankles/extremities ☐ Abdominal pain ☐ Bloating
☐ Constipation ☐ Diarrhea ☐ Food intolerance
☐ Dysphagia/difficulty swallowing ☐ Indigestion ☐ Nausea/vomiting
☐ Increased appetite ☐ Decreased appetite ☐ Heartburn
☐ Gas and bloating ☐ Urinary frequency/urgency ☐ Slow urine flow
☐ Nighttime urination ☐ Blood in stools ☐ Back pain (upper)
☐ Back pain (lower) ☐ Joint pain ☐ Muscle aches/pain
☐ Dizziness ☐ Headaches ☐ Seizures

☐ Weakness/low energy
☐ Insomnia
☐ Mood changes
☐ Cold intolerance
☐ Heat intolerance
☐ Anxiety
☐ Memory loss
☐ Nervousness
☐ Excessive sweating
☐ Blood clots
☐ Depression
☐ Inability to concentrate
☐ Loss of interest
☐ Hair changes
☐ Fatigue/tiredness

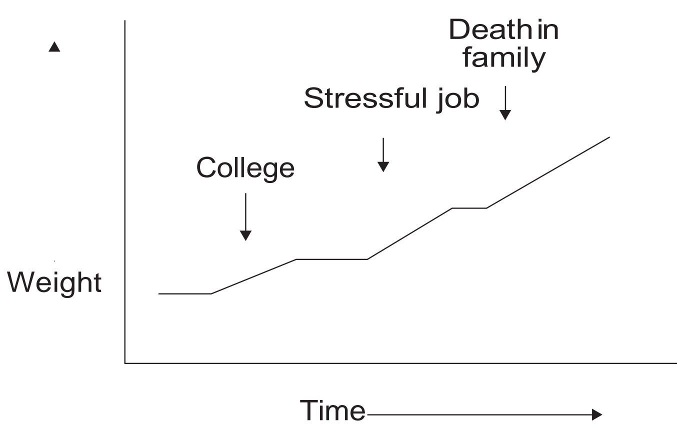
(Women only)

☐ Absence of periods
☐ Abnormal/excessive menstruation
☐ Hot flashes
☐ Facial hair
☐ Change in bladder habits

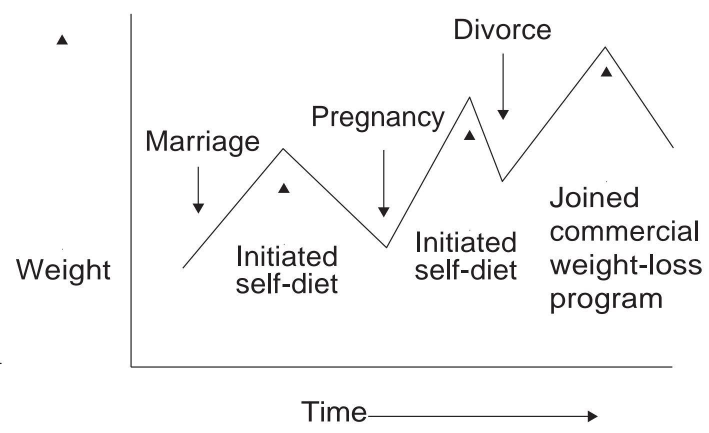
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

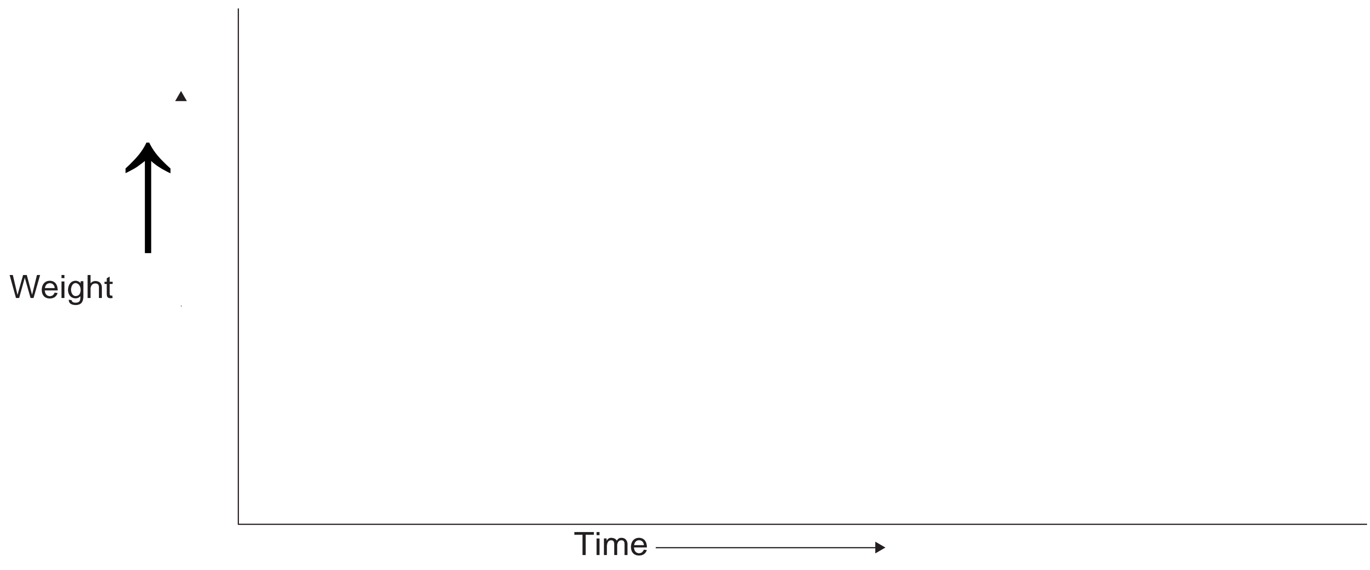
Progressive (or Ratcheting) Weight Gain



Weight Cycling or "Yo-Yo" Weight Gain



Please draw a graph of your weight gain. Mark *life events* and *diet attempts* that have contributed to your current weight.



Adapted from *Dr. Kushner's Personality Type Diet.* Copyright 2009 Robert Kushner, MD.

Patient Signature: ______________________________________ Date: ____/____/________