ReforMedicine SC

Direct Pay Family Practice

Medical Weight Loss History Form

Name: _____ Age:_____

Tell Us The Story of You:

Are you (circle one): married never married divorced/widowed other?

Who **lives at home** with you?_____

What do you do **for a living**?_____ Employer:_____

Do you smoke/chew **tobacco**? Yes No Quit_____ years ago How much?_____/wk

How much **alcohol** do you drink? None _____per day _____per week

Do you use any **recreational substances** (e.g. Marijuana)? Yes No

What do you do **now** for **exercise** and how often? None _____, _____min,_____days/week
(type of exercise)

How many **hours per week** do you spend watching TV/playing video games/web-surfing? _____

How many **children** do you have?_____ What are their ages?_____

In what **town** do you live? _____

Who is your regular doctor?_____, Town/City_____

How did you decide to come to ReforMedicine to help you with your weight?_____

_____

_____

_____

_____

Your Vision for Your Future

How much would you **like to weigh**? _____pounds (your "goal weight")

In what **time frame** would you like to be at your desired weight? _____

What are the **most important reasons** for your decision to lose weight? (list as many as you can think of, use back of page if needed)

Your Starting Point

How did you become overweight? _____

_____

Have you ever taken a medication(s) that caused you to gain weight? No Yes If so, please list each:

_____

What was **YOUR** weight at 20 years of age: _____ One year ago: _____

What has been your **maximum lifetime weight** (non-pregnant) and when?_____

Do you have a **significant other who is overweight**? Yes No By how much? _____Pounds

How often do you **eat out**? _____times per week

Food allergies/intolerances: _____ Food **dislikes**:_____

Food(s) you **crave**: _____

Are there any specific **times that you crave food**? If so when? _____

What **sugared beverages** do you drink routinely:
Juice Regular soda Sweetened Tea Sports drinks Coffees Other

Do you awaken **hungry during the night**? Yes No
What do you do? _____

What are your **worst food habits**? _____

Snack Habits: What? _____ How much? _____ When? _____

When you are under a **stressful situation** at home or work, do you tend to **eat more**?
If yes, Explain: _____

Are you **currently** undergoing a **stressful situation** or an emotional upset?
Explain:_____

How **is your current** stress level? Low Medium High

Briefly tell us about your **usual eating patterns**:

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Where: _____	Where: _____	Where: _____

What **weight loss programs** have you done before? Give approximate dates and results

Have you ever used medications for weight loss? If so, which?_____

Body Systems Review

Describe your **usual energy level**: _____

Do you usually snore? Yes No If so loudly? Yes No Most Nights? Yes No
Do you wake up most days feeling well rested? Yes No

Circle any of the following problems **YOU now** experience:

Headaches	Wheezing	Jaundice/yellow skin	Mental problems
Vision/hearing problems	Fainting Spells	Tummy Pain	Trouble sleeping
Trouble swallowing	Rapid heart beats	Leg/ankle swelling	Worry too much
Heartburn/Acid Reflux	Rash	Numbness/Tingling	Mood swings
Chest Pain	Fever	Severe Pain	Panic attacks/Worry too much
Shortness of breath	Diarrhea	Hair loss	Eating till you feel guilty
Cough	Vomiting	Dry Skin	Other:

Gynecologic History: (Women only)

What date did your last menstrual period start:? _____
How many times have you been pregnant? _____
How old were you when you had your first menstrual period? _____years old
How long do your periods last? _____days
How often do you get your periods? Every _____ weeks
Are your periods regular? (predictable?) Yes No
Are they more painful than you think they should be? Yes No
Are you currently using: Birth Control Pills? Yes No Type: _____
Hormone Replacement Therapy? Yes No Type: _____
When was your last pap smear?_____
Have you ever had a pap smear that required treatment? Yes No Year

Your Past Medical History: (check all that apply to YOU):

Depression		Rheumatic Fever		Bleeding Disorder	
Anxiety		Tuberculosis		Anemia	
Drug Abuse		Pneumonia		Blood Transfusion	
Alcohol Abuse		Scarlet Fever		Arthritis	
ADHD/ADD		Whooping Cough		Osteoporosis	
PTSD		Measles		Asthma	
Binge Eating Disorder		Mumps		Allergies	
Psychiatric illness		Tonsillitis		Lung Disease	
Anorexia/Bulimia		Chicken Pox		Insomnia	
Kidney Problems		Liver Disease		Headaches/Migraines	
Swelling Feet		Constipation		Glaucoma	
Heart Valve Disorder		Gallbladder Disorder		Gout	
High Blood Pressure		Jaundice		Thyroid Disease	
Diabetes		Ulcers		**Other**_____	
Heart Condition		Cancer			

Are you in good health at the present time to the best of your knowledge? Yes No
Explain a "no" answer:

Are you under a doctor's care at the present time? Yes No
If yes, for what?

Serious Injuries/Traumas: Yes No
Specify (List all) Date

Surgeries/Hospitalizations: Yes No
Specify: (List all) Date

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Have any of your **parents, brothers, sisters, or children** ever had any of the following:

Stroke Yes No Who: _____
Heart Disease Yes No Who: _____
High Blood Pressure Yes No Who: _____
Kidney Disease Yes No Who: _____
Diabetes Yes No Who: _____
Psychiatric Disorder Yes No Who: _____
Cancer Yes No Who: _____
Other Serious Illness Yes No Who: _____

Your Medications:

List any **allergies or problems you have experienced** with **any** medications:_____

_____

Are you taking any medications at the **present** time? Yes No

Prescription Drugs: None

Drug (List all):	Dose:	How Often?

Over-the-Counter **medications, vitamins, supplements:** None

Product (List all)	Dose	How Often?

Thank you for your time and patience in completing this form. Please remember to bring it with you to your appointment.