



**Medical Weight Loss and Wellness**  
11665 Highway 6 South, Sugar Land, TX 77498  
Office: 281.201.8243 Fax: 281.903.7135  
www.mwlw-health.com

## Patient Medical History Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

### What is the purpose of your visit today?

---

---

Please list all your medications and dosage, including over-the-counter meds and vitamins:

---

---

Please list any allergies to food or medications:

---

---

### Past Medical History (check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Cancer, Type: _____      | <input type="checkbox"/> Colon Polyps    |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Kidney Stones   |
| <input type="checkbox"/> High Cholesterol         | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Kidney Disease  |
| <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Obstructive Sleep Apnea  | <input type="checkbox"/> Gout            |
| <input type="checkbox"/> Heart Arrhythmia         | <input type="checkbox"/> Peptic Ulcer Disease     | <input type="checkbox"/> Depression      |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Gastro esophageal Reflux | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Stroke / TIA             | <input type="checkbox"/> Diverticulosis           | <input type="checkbox"/> Other _____     |

Are you currently taking any blood thinning medications?  yes  no

If yes, please list the medications and the conditions for which they are prescribed:

---

Are you currently using a CPAP machine?  yes  no

### Past Surgical History

---

---



**Nutritional Evaluation**

Present Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Height (without shoes): \_\_\_\_\_ Current Clothing Size: \_\_\_\_\_ Desired Clothing Size: \_\_\_\_\_

How fast do you want to lose the weight? \_\_\_\_\_

What is the main reason why you want to lose weight? \_\_\_\_\_

Who encouraged you to lose weight? \_\_\_\_\_

Do your family and friends support your weight loss efforts?  yes  no

Do you feel you eat because of emotions?  yes  no

If yes, please explain: \_\_\_\_\_

What weight loss program(s) have you tried in the past, and what were the results?

\_\_\_\_\_  
\_\_\_\_\_

Food Allergies: \_\_\_\_\_ Food Cravings: \_\_\_\_\_

Food Dislikes: \_\_\_\_\_

Do you eat fast foods?  yes  no

If yes, how often? \_\_\_\_\_

What are your worst food habits? \_\_\_\_\_

What do you normally eat for:

Breakfast?	Lunch?	Snack?	Dinner?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is most important to you in deciding to enroll into you program? (please check all that apply)

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Effectiveness<br>"My results are top priority" | <input type="checkbox"/> Time<br>"I want results quickly" | <input type="checkbox"/> Service<br>"I want help when I need it" | <input type="checkbox"/> Ease<br>"I have a difficult time losing weight" |
|---|---|--|--|

## Review of Systems

Please check the items that apply.

### Head and Neck

- Eye pain
- Eye drainage
- Hearing loss
- Ear pain
- Ear drainage
- Ringing in ears
- Sinus pain or pressure
- Allergies
- Nasal congestion
- Sore Throat
- Runny nose
- Sneezing
- Frequent nosebleeds
- Bleeding gums
- Dental problems
- Sores in mouth
- Hoarseness
- Swelling in neck

### Energy

- Fatigue
- Heat or cold intolerance
- Generalized weakness
- Lethargy
- Restlessness
- Hyperactivity

### Cardiac

- Chest pain or pressure
- Racing heartbeat
- Palpitations
- Swelling of ankles

### Pulmonary

- Waking up at night short of breath
- Daytime sleepiness
- Snoring
- Stop breathing during sleep
- Short of breath when lying flat
- Shortness of breath
- Wheezing
- Persistent cough
- Coughing up blood

### Digestive

- Abdominal pain
- Nausea/vomiting
- Heartburn
- Vomiting blood
- Pain with swallowing
- Difficulty swallowing
- Blood in stool
- Black bowel movements
- Constipation
- Diarrhea

### Skin

- Skin rash
- Dry skin
- Changing mole
- Joint pain or swelling
- Skin ulcer or non-healing sore
- Lumps or bumps
- Excessive sweating

### Emotional & Mental

- Anxiety
- Depression
- Impaired sexual function
- Mood swings
- Irritability
- Poor Concentration

### Genital Urinary

- Burning with urination
- Excessive urination
- Incontinence of urine
- Urinary urgency
- Urinary frequency
- Getting up to urinate at night
- Weakened urine stream
- Blood in urine

### Neurological

- Numbness or tingling
- Slurred speech
- Loss of consciousness
- Loss of vision
- Loss of balance
- Seizures
- Double vision
- Paralysis
- Tremor
- Severe headaches
- Dizziness

### Other Symptoms

- Unexplained weight loss/gain
- Trouble sleeping
- Excessive thirst
- Fever and chills

**My signature below warrants that I have completed this questionnaire truthfully and accurately.** My records will be kept confidential and will only be shared with staff. My written consent is required for any sharing of information outside of Medical Weight Loss and Wellness.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_