



### MEDICAL HISTORY FORM

<b>NAME</b>	<b>DOB</b>	<b>DATE</b>
<b>GENDER:</b> <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	<b>RACE:</b> <input type="checkbox"/> CAUCASIAN <input type="checkbox"/> AFRICAN-AMERICAN/BLACK <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NOT HISPANIC/LATINO <input type="checkbox"/> NATIVE AMERICAN/ALASKA NATIVE <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER (SPECIFY):	

**REASON FOR VISIT**

**HOW LONG HAVE YOU BEEN CONSIDERING TREATMENT?**

SOCIAL HISTORY	
<b>OCCUPATION</b>	<b>MARITAL STATUS</b>
<b>SMOKING</b> <input type="checkbox"/> DENIED <input type="checkbox"/> YES    Pack per Day _____    How Long _____    Quit Date _____	
<b>ALCOHOL USE</b> <input type="checkbox"/> NONE <input type="checkbox"/> RARE <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> FREQUENT	<b>HISTORY of ALCOHOL ABUSE:</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>RECREATIONAL DRUG USE</b> <input type="checkbox"/> DENIED <input type="checkbox"/> MARIJUANA <input type="checkbox"/> COCAINE <input type="checkbox"/> HEROIN <input type="checkbox"/> PAIN MEDS <input type="checkbox"/> METH	

SURGICAL HISTORY (Past Surgeries with Dates)		
<b>BREAST</b>	<b>ABDOMEN</b>	<b>FACIAL</b>
<b>COSMETIC:</b>	<b>OTHER:</b>	

**Surgical Complications:**

<b>ANESTHESIA PROBLEMS</b>
<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>Explain:</b> _____

PAST MEDICAL HISTORY			
NONE	<input type="checkbox"/> YES <input type="checkbox"/> NO	HIV / AIDS	<input type="checkbox"/> YES <input type="checkbox"/> NO
BREAST CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO	KIDNEY	<input type="checkbox"/> YES <input type="checkbox"/> NO
BLEEDING TENDANCY	<input type="checkbox"/> YES <input type="checkbox"/> NO	LIVER DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
DIABETES	<input type="checkbox"/> YES <input type="checkbox"/> NO	LUNG DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
EYE PROBLEMS	<input type="checkbox"/> YES <input type="checkbox"/> NO	MENTAL ILLNESS	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART DISEASE/MI	<input type="checkbox"/> YES <input type="checkbox"/> NO	NEUROLOGIC DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO
HEART MURMUR	<input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
HIGH BLOOD PRESSURE	<input type="checkbox"/> YES <input type="checkbox"/> NO	SKIN CANCER	<input type="checkbox"/> YES <input type="checkbox"/> NO
HISTORY DVT/PE	<input type="checkbox"/> YES <input type="checkbox"/> NO	THYROID DISEASE	<input type="checkbox"/> YES <input type="checkbox"/> NO

FAMILY HISTORY (indicate which Blood Relative)		
SKIN CANCER	DIABETES	STROKE
BREAST CANCER	HEART DISEASE	ABNORMAL BLEEDING
OTHER CANCER	MALIGNANT HYPOTHERMIA	OTHER

Please describe any other aspects of your family history that you feel is pertinent to your health. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CURRENT MEDICATIONS**

<input type="checkbox"/> See List Please list dosage and schedule		<input type="checkbox"/> None	
1.	4.		
2.	5.		
3.	6.		
<b>NON-PRESCRIPTION DRUGS</b>			
ASPIRIN: <input type="checkbox"/> YES <input type="checkbox"/> NO		IBUPROFEN: <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOMEOPATHIC: <input type="checkbox"/> YES <input type="checkbox"/> NO		SBE PROPHYLAXIS: <input type="checkbox"/> YES <input type="checkbox"/> NO	

Steroids in the last 12 months:  Yes  No  
 Do you take a Blood Thinner?  Yes  No Name: \_\_\_\_\_

Allergies to Medications:  
 Penicillin       Lidocaine    Other: \_\_\_\_\_  
 Latex            Tape

Have you had recent weight gain?  Yes  Recent weight loss \_\_\_\_ lbs loss \_\_\_\_ lbs gain

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Body Mass Index (BMI): \_\_\_\_\_

At what weight would you feel comfortable to maintain? \_\_\_\_\_ lbs

**REVIEW OF SYSTEMS**

Fever / Chills: <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Ulcer: <input type="checkbox"/> Yes <input type="checkbox"/> No Night Sweats: <input type="checkbox"/> Yes <input type="checkbox"/> No Reflux: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No Back/Neck Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No Double Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No Nerve Pain/Paralysis: <input type="checkbox"/> Yes <input type="checkbox"/> No Dry Eye: <input type="checkbox"/> Yes <input type="checkbox"/> No Facial Weakness: <input type="checkbox"/> Yes <input type="checkbox"/> No Nasal Obstruction: <input type="checkbox"/> Yes <input type="checkbox"/> No Depression/Anxiety: <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Urinating: <input type="checkbox"/> Yes <input type="checkbox"/> No Drug or Alcohol Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding Tendency: <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Swallowing: <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No Speech Changes: <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged Thyroid/Goiter: <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No Enlarged Gland/Node: <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain or Tightness: <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Sunburns: <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma/Breathing Problems: <input type="checkbox"/> Yes <input type="checkbox"/> No Scarring/ Keloids: <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath: <input type="checkbox"/> Yes <input type="checkbox"/> No Renal Failure/Dialysis: <input type="checkbox"/> Yes <input type="checkbox"/> No Breast Mass/Lump: <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No
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**FEMALE PATIENTS**

Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you take birth control pills? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you Planning Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a c-section? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____
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When was your last mammogram? \_\_\_\_\_  1 year  5 year

Patient / Parent's Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed with Patient By: \_\_\_\_\_ Date: \_\_\_\_\_

Addendum's: \_\_\_\_\_ Date: \_\_\_\_\_

Updated with Patient By: \_\_\_\_\_ Date: \_\_\_\_\_

Please describe below, or on the back, any other medical problems or concerns you have or have had in the past recent years.

Previous Weight Loss Attempts

Year	How much did you lose?	WEIGHT LOSS TECHNIQUE					
		"On my own"	Commercial diet	Diet Supplements (eg. Optifast)	High protein/ low carb	Drugs	Surgery

Have you ever had a complication or bad experience from weight loss? Yes \_\_\_\_\_ No \_\_\_\_\_

Has any weight loss method worked well for you in the past? If so, please describe. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this is my true medical history, to the best of my knowledge.

Signed \_\_\_\_\_ Date: \_\_\_\_\_