Text

Description automatically generated with medium confidence**NEW CLIENT MEDICAL HISTORY FORM**

Name (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (MI)\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (Home/Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Work)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How does your weight affect your life and health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Weight History**

When did you first notice that you were gaining weight?

\_\_Childhood \_\_Teens \_\_Adulthood \_\_Pregnancy \_\_Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? \_\_\_\_\_\_\_\_\_\_

How much did you weigh: one year ago? \_\_\_\_\_ Five years ago? \_\_\_\_\_ Ten years ago? \_\_\_\_\_\_

Life events associated with weight gain (check all that apply):

\_\_Marriage \_\_Divorce \_\_Pregnancy \_\_Abuse \_\_Illness

\_\_Travel \_\_Injury \_\_Nightshift work \_\_Job change \_\_Quitting smoking

\_\_Alcohol \_\_Drugs

\_\_Medication (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_Weight Watchers \_\_Nutrisystem \_\_Jenny Craig \_\_Intermittent fasting

\_\_South Beach \_\_Medifast \_\_Atkins \_\_Mediterranean

\_\_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 (Apidex) \_\_Phen/Fen \_\_Wegovy \_\_Topamax \_\_Plenity

\_\_Phendimetrazine (Bontril) \_\_Belviq \_\_Contrave \_\_Tirzepatide \_\_Diethylpropion

\_\_Bupropion (Wellbutrin)

Other (including supplements): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What worked? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What didn’t work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nutritional History**

How often do you eat breakfast? \_\_\_\_\_ days per week at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AM

Number of times you eat per day: \_\_\_\_\_ What beverages do you drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get up at night to eat? Y / N If so, how often? \_\_\_\_\_\_times

List any food intolerances/restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

How much water do you drink per day? \_\_\_\_\_\_\_\_\_\_\_\_oz/day

Food triggers (check all that apply):

\_\_Stress \_\_Boredom \_\_Anger \_\_Insomnia \_\_Seeking reward

\_\_Parties \_\_Eating out \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food cravings:

\_\_Sugar \_\_Chocolate \_\_Starches \_\_Salty \_\_Fast food

\_\_High fat \_\_Large portions

Favorite foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Exercise type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Duration: \_\_\_\_\_hours \_\_\_\_\_minutes Number of times per week: \_\_\_\_\_

Does anything limit you from exercising? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you snore? Yes / No Do you wear a C-Pap? Yes / No

Past medical history (check all that apply):

\_\_Heart Attack \_\_Angina \_\_Galbladder stones \_\_Sleep apnea

\_\_High Blood Pressure \_\_Stroke \_\_Indigestion/reflux \_\_Thyroid

\_\_High cholesterol \_\_Diabetes \_\_Celiac disease \_\_Anxiety

\_\_High triglycerides \_\_Gout \_\_Pancreatitis \_\_Depression

\_\_Infertility \_\_Arthritis \_\_Polycystic Ovarian Syndrome

\_\_Glaucoma \_\_Bipolar \_\_Cancer (Types): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? \_\_\_\_\_\_\_\_\_\_\_

Past Surgical history (check all that apply):

\_\_Gastric bypass \_\_Gastric banding \_\_Gastric sleeve \_\_Galbladder \_\_Heart bypass \_\_Hysterectomy Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (list all current medications, including over-the-counter meds, supplements, herbs):

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

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

Allergies:

(Medications) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Foods) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Smoking: \_\_\_Never \_\_\_Current smoker (\_\_\_\_ppd) \_\_\_Past smoker )quit\_\_\_\_yrs ago)

Alcohol: \_\_\_Never \_\_\_Occasional \_\_\_Regularly (\_\_\_\_\_drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: \_\_\_Never \_\_\_Current \_\_\_Past Type of drugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 \_\_\_Anxiety

\_\_\_Depression \_\_\_Bipolar disorder \_\_\_Alcoholism

\_\_\_Thyroid problems \_\_\_Alcoholism \_\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Cancer (type/s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecologic History**

Age periods started? \_\_\_\_\_ Age periods ended? \_\_\_\_\_

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: \_\_\_\_\_\_ Number of children: \_\_\_\_\_

Age of first pregnancy: \_\_\_\_\_ Age of last pregnancy: \_\_\_\_\_

\_\_\_Absence of periods \_\_\_Hot flashes \_\_\_Change in bladder habits

\_\_\_Abnormal/excessive menstruation \_\_\_Facial hair

\_\_\_Difficulty in getting pregnant \_\_\_Easy bruising

**Men Only**

\_\_\_Difficulty in getting erections \_\_\_Low testosterone

**System Review**

(Check all that apply)

\_\_\_Recent weight loss of more than 10 lbs \_\_\_Recent weight gain of more than 10 lbs

\_\_\_Fatigue/tiredness \_\_\_Acne \_\_\_Abdominal pain

\_\_\_Weakness/low energy \_\_\_Hair changes \_\_\_Bloating

\_\_\_Cold intolerance \_\_\_Skin rash \_\_\_Constipation

\_\_\_Heat intolerance \_\_\_Dizziness \_\_\_Diarrhea

\_\_\_Excessive sweating \_\_\_Headaches \_\_\_Food intolerance

\_\_\_Cough \_\_\_Fainting/blacking out \_\_\_Indigestion.

\_\_\_Difficulty breathing (up or flat) \_\_\_Seizures \_\_\_Nausea/vomiting.

\_\_\_Snoring \_\_\_Anxiety \_\_\_Difficulty swallowing

\_\_\_Palpitations \_\_\_Depression \_\_\_Increased appetite

\_\_\_Chest pain \_\_\_Insomnia \_\_\_Decreased appetite

\_\_\_Blood clots \_\_\_Memory loss \_\_\_Heartburn

\_\_\_Vision Changes \_\_\_Inability to concentrate \_\_\_Gas and bloating

\_\_\_Back pain (upper \_\_\_Mood changes \_\_\_Blood in stools

\_\_\_Back pain (lower) \_\_\_Nervousness \_\_\_Slow urine flow

\_\_\_Muscles aches/pain \_\_\_Loss of interest (general) \_\_\_Nighttime urination

\_\_\_Swelling ankles/extremities \_\_\_Loss of interest in sex \_\_\_Urinary urgency/

\_\_\_Joint pain frequency

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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