

Patient Name: _____

In your own words, please describe what you hope to accomplish and how you believe your life will change by losing weight: _____

DIETARY HISTORY

Approximate age when you first seriously dieted: _____

List the diets and diet programs you have tried:

Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Dates	Duration	MD Supervised?	Max Loss
Jenny Craig:	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Nutri-Systems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Weight Watchers	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
OptiFast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Medi Fast	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Fen/Phen/Redux	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Meridia	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Lindora	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
T.O.P.S.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
O.A.	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Metabolife	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Atkins Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____
Pritikin Diet	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____

List any physician-supervised and documented weight loss attempt: _____

List any other diets and/or weight loss methods you've tried: _____

For female patients only:

Pregnancy #1 Year _____ Weight at start _____ at delivery _____

Pregnancy #2 Year _____ Weight at start _____ at delivery _____

Pregnancy #3 Year _____ Weight at start _____ at delivery _____

Pregnancy #4 Year _____ Weight at start _____ at delivery _____

FOOD PREFERENCES

Indicate which foods you prefer (which foods would most likely make you go off a diet).

Rank each selection from 1- like very much to 4- don't care.

_____ Soda/Soft drinks

_____ French fries

_____ Chips/snacks

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_____ Steaks/chops _____ Candy _____ Potatoes
 _____ Chocolate _____ Pasta _____ Cookies
 _____ Pizza _____ Cakes/pies _____ Salad dressings
 _____ Fried foods

WEIGHT-RELATED ILLNESSES

Have you had, or do you have, any of the following illnesses or symptoms?

1. Heart Disease Yes No

If Yes: ♦ Year Diagnosed _____

Do you have, or have you had:

- Angina
- M.I. (myocardial infarction)
- CABG (coronary artery bypass graft)
- Abnormal EKG
- Stress test to rule out cardiac problems
- Palpitations

2. High Cholesterol Yes No High Triglycerides Yes No

If Yes: ♦ Year Diagnosed _____

♦ List medications _____

3. High Blood Pressure Yes No

If Yes: ♦ Year Diagnosed _____

♦ List medications _____

4. Diabetes Yes No

If Yes: ♦ Year Diagnosed: _____

♦ Gestational: Yes No

♦ Neuropathy: Yes No

♦ Controlled with: Diet

Oral Medication (list) _____

♦ Last fasting blood sugar: _____

5. Asthma Yes No

If Yes: ♦ Year Diagnosed: _____

♦ ER visits/last 2 yrs: _____

♦ Hospitalizations last 2 years: _____

♦ Steroids last 2 years: Yes No

Patient Name: _____

6. Shortness of breath Yes No

If Yes, : ♦ Can walk _____ blocks

♦ Stairs: _____ flights

7. Trouble Sleeping? Yes No

♦ Morning headaches Yes No

♦ Daytime drowsiness Yes No

♦ Restless sleep Yes No

♦ Snoring Yes No

♦ Awakenings at night Yes No

♦ Observed apneas Yes No

Office Use: sleep study ordered _____ initials

8. Sleep Apnea Syndrome Yes No

If Yes: ♦ Year Diagnosed: _____

♦ Last sleep study: _____ month/year

♦ CPAP used: Yes No

9. Heartburn/esophagitis/hiatus hernia? Yes No

If Yes: ♦ Year Diagnosed: _____

♦ Upper GI series? Yes No

♦ Endoscopy? Yes No

♦ Medications: _____

♦ Frequency of use: _____

10. Belching up acid or sour fluid. Yes No

11. Coughing or choking at night? Yes No

Office Use: UGI/endoscopy

12. Gallbladder disease? Yes No

If Yes: -How was it Diagnosed? Ultrasound Physical Exam

13. Leakage of urine with laughing/coughing/sneezing? Yes No

If Yes: ♦ Wear pads frequently? Yes No

15. Low back strain/Pain/Sciatica? Yes No

If Yes: ♦ Seen by Chiropractor? Yes No

♦ Orthopedic Surgeon? Yes No

♦ Seen by Family Doctor? Yes No

♦ Medications taken: _____

Patient Name: _____

16. Pain in Hips/Knees/Ankles/Feet? Yes No

If Yes: ♦ Seen by Chiropractor? Yes No

♦ Orthopedic Surgeon? Yes No

♦ Seen by Family Doctor? Yes No

♦ Medications taken _____

17. Weight related injuries and trauma: _____

18. Venous Stasis Disease? Yes No

If Yes: ♦ Do you have Edema? Yes No

♦ Scaly & Thick Skin? Yes No

♦ Leg Ulcers? Yes No

19. Gout? Yes No

If Yes: ♦ Gouty Arthritis? Yes No

Using Medication? _____

Have you ever taken Allopurinol? Yes No When? _____

20. Bra size (females only): _____

Skin depressions from bra straps? Yes No

Do you have shoulder pain? Yes No

PAST MEDICAL HISTORY

Please identify which of the following childhood illnesses you have experienced:

- | | | | |
|--|---------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Asthma | <input type="checkbox"/> Tonsillectomy |

Female Patients:

Number of pregnancies: _____ Age at first period: _____

Number of live births: _____ Date of last period: _____

Miscarriages/abortions: _____

Obstetric complications: _____

Do you presently use:

Birth control pills Yes No List type: _____

Estrogens Yes No List type: _____

Other Contraceptive method: _____

Patient Name: _____

SERIOUS ILLNESSES

Have you had:

- Hepatitis Blood Transfusion AIDS/HIV Exposure
 Colitis Kidney Disease Bleeding Abnormality
 Thyroid Problems _____

Please list below all serious illnesses and hospitalizations you have experienced in adulthood:

Major Illness	Date	Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Major Surgery	Date
_____	_____
_____	_____
_____	_____

Allergic to any medications? Yes No If Yes, please list medication and reaction:

Allergic to: **Surgical tape:** Yes No **Latex:** Yes No **Iodine:** Yes No
Other Allergies:

Medications:

Please list below all medications you currently use:

Medication	Dose and Frequency

Do you use tobacco: Yes No Frequency: _____
Are you willing to quit? Yes No
Do you use alcohol: Yes No Frequency: _____

Patient Name: _____

FAMILY HISTORY

Family Member	Living?	Age	If Deceased, age	Illness/Cause of death
Mother				
Father				
Maternal Grandmother				
Maternal Grandfather				
Fraternal Grandmother				
Fraternal Grandfather				
Sibling:				
Sibling:				
Sibling:				
Sibling:				

Please indicate if there is a family history of:

- | | |
|---|--|
| <input type="checkbox"/> Obesity | <input type="checkbox"/> Lung disease, Asthma or Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding tendency or Blood Disorder |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Breast Cancer |
| <input type="checkbox"/> High Blood Cholesterol | <input type="checkbox"/> Colon Cancer |

PERSONAL PHYSICIANS

Please list all the physicians under whom you receive medical care:

	Name	Address/Location	Telephone
Primary Care Physician	_____	_____	_____
Internist	_____	_____	_____
Gynecologist	_____	_____	_____
Orthopedist	_____	_____	_____
Psychiatrist	_____	_____	_____
Psychologist	_____	_____	_____
Therapist	_____	_____	_____
Other	_____	_____	_____

Patient Name: _____

SYSTEM REVIEW

Please circle all symptoms you currently experience, or have experienced in the past. Feel free to add any additional problems or information.

1. HEAD, EYE, EAR, NOSE & THROAT: stuffy nose – runny nose – hay fever – sinus trouble – earache – headache – blurry vision – double vision – haloes around lights – loss of night vision – buzzing in ears – ringing in ears – discharge from ear – loss of hearing – dizziness – vertigo – loss of balance – sore throat – lump in throat – trouble swallowing – pain with swallowing – hoarseness

2. RESPIRATORY: cough – wheezing – shortness of breath at night – use of two pillows – blood in sputum – out of breath with exertion – wake up at night short of breath – wake up at night coughing or choking – asthma – emphysema – bronchitis

3. CARDIOVASCULAR: palpitations – pounding heart – skipping heartbeat – pains in chest – pains in neck – pains in arms – squeezing of chest – heart attack – heart murmur – abnormal electrocardiogram – irregular heartbeat – high blood pressure – pain in legs – cold feet – blue toes – blue finger – loss of pulses

4. GASTROINTESTINAL: heartburn – nausea – vomiting – belching fluid in throat – burning in throat – food sticking in chest – pains in stomach – burning in stomach – acid stomach – diarrhea – constipation – pain with bowel movement – blood in stools – hemorrhoids – fissures – cramps – gassiness – irritable colon – colitis

5. GENITOURINARY: pain with urination – trouble starting urine – trouble stopping urine – small urine stream – blood in urine – kidney stones – bladder stones – kidney failure – nephritis – urinary tract infections – frequent urination – getting up at night to urinate – leakage of urine with cough or sneeze

◆ Men: Discharge from penis – loss of erection – painful erection

◆ Women: Vaginal discharge – vaginal bleeding – pain with intercourse – irregular periods

6. ENDOCRINE (GLANDULAR): low thyroid – hyperthyroid – goiter – Grave's Disease – thyroid Nodules – X-ray to thyroid – diabetes – adrenal gland tumor – frequent flushing – frequent heavy sweating

7. MUSCULOSKELETAL: pain in joints – swelling of joints – redness of skin over joints – warm joints – fluid in joints – arthritis – broken bones – sprains – low back pain – hip pain – knee pain – ankle pain – foot pain – flat feet – slipped disk – herniated disk – sciatica

8. NEUROLOGICAL: dizziness – vertigo – falling to the side – falling at night – numbness – tingling – pins and needles feelings – weakness of any muscles – twitching of muscles – weakness of grip – shakiness – tremors – fainting – convulsions – fits – loss of consciousness

PSYCHOLOGICAL: nervousness – anxiety – depression – thoughts of suicide – suicide attempts – hospitalization for emotional problems – psychiatric treatment – psychological counseling