Patient Medical History Form

Date ___________________

NOTE: This form must be completed before you can be enrolled in our weight loss program. Please answer every question. Please print, type or write clearly.

Name (Last-First-Initial)		Email Address	
Address (Street-City-State-Zip)		Daytime Phone No.	
Occupation	Name of Employer	Evening Phone No.	
Birth date (Month-Day-Year)	Circle Marital Status Single Married Divorced Separated Widowed		SEX (CIRCLE) MALE FEMALE

Please give the name and address of a friend or relative with a stable address (for emergency)

Name (Last-First-Initial)	Address (Street-City-State-Zip)	Phone No.

WEIGHT HISTORY

Patient weight (lbs)

Present height (feet, inches)

What is your goal weight?

When did you last weight this amount?

Indicate ages during which you were overweight

- □ Childhood (Age 2-11 yrs)
- □ Adolescence (Age 12-19 yrs)
- □ Age 20-29 yrs
- □ Age 30-40 yrs
- □ Over 40 yrs

How much weight do you expect to lose during this program? _________ lbs.

Which weight loss methods have you tried in the past? Please be as specific as possible (ex NutriSystem, Jenny Craig, Starvation, Protein Formula, Medications, Spa, Hypnosis, Weight Watchers, Psychotherapy, Etc.)

Weight loss method	How long was loss maintained?	Why did you stop treatment?	Problems during treatment
Sample: Stillman Diet	*2 months*	*Desired other foods*	*Dizziness*

Which weight loss method do you consider your most successful?

What accounted for that success?

MEDICAL HISTORY

Physician to receive your progress reports:

Name | Office Address | Phone

When was your most recent complete physical exam? Month: Year:

Please list all medical conditions you have been diagnosed with AND all medications, over the counter medications, vitamins, and supplements you are currently taking.

Medical Conditions	Medications (include dosage), Vitamins and Supplements
	Allergies to medications

Please check any health condition you have:	☐ Peptic ulcer disease that is not resolved or under good medical control
☐ Heart attack within last 3 months	☐ Recent onset of inflammatory bowel disease
☐ Insulin-dependent diabetes (juvenile-onset diabetes)	☐ Non-insulin dependent diabetes
☐ Liver disease requiring protein restriction	☐ Other (Explain) Fertility/Pregnancy issue?
☐ Pregnant or planning to become pregnant within 6 months	
☐ Kidney disease requiring protein restriction	Date of most recent menstrual period _____________
☐ Recent treatment for cancer (please describe)	Number of pregnancies ____________
☐ Recent uric acid kidney stone or untreated hyperuricemia (gout)	Weight gain with pregnancies ____________ lbs

PSYCHOSOCIAL HISTORY

Are you at present undergoing any major lifestyle changes (e.g., marriage, divorce, job change, death of someone important to you)? If so, describe:

What other commitments do you have that might interfere with your fully participating in this program?

What benefits do you hope to gain from being in this program other than losing weight?

Who do you feel will be supportive of your weight loss and changes in lifestyle? (circle and name your choices)

Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

Who do you feel may **not** be supportive of your weight loss and changes in lifestyle? (circle and name your choices)

Spouse Children Roommate(s) Parent(s) Friend(s) Co-worker(s) Other

PSYCHOSOCIAL HISTORY (CONT.)

List five reasons you think it is important for you to lose weight. Please number the reasons, with “1” being the most important.

1.
2.
3.
4.
5.

Why did you choose this particular program?

How did you hear about Rochester Medical Weight Loss?

Are you currently in any kind of psychotherapy/counseling? ☐ YES ☐ NO
If yes, please specify:

With whom	For what	Date treatment began

Have you been in any kind of psychotherapy/counseling in the past? ☐ Yes ☐ No
If yes, please specify:

With whom	For what	Date treatment began	Ending date

Have you ever been hospitalized for psychiatric reasons? If so, please complete the following:

Date of Admission	Length of Stay	Reason for Hospitalization

Have you ever had suicidal thoughts? ☐ Yes ☐ No

Have you ever been severely depressed? ☐ Yes ☐ No ☐ Possibly

Have you ever experienced dramatic mood changes during dieting (especially anxiety or depression)? ☐ Yes ☐ No ☐ Possibly

Have you ever eaten a large amount of food rapidly and felt this eating incident was excessive and out of control (aside from holiday feasts)? ☐ Yes ☐ No

If yes, how often did you do this during the past year? (check one)

☐ Less than once a month
☐ About once a month
☐ A few times a month
☐ About once a week
☐ About three times a week
☐ Daily

Have you ever purged (used self-induced vomiting, laxatives, or diuretics)? o Yes o No

LIFESTYLE AND EATING HABITS

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much?
☐ 1 drink a month
☐ 1 drink a week
☐ More than 1 drink a week
☐ 1 drink a day
☐ More than 1 drink a day

How often do you exercise?
☐ Rarely
☐ Occasionally
☐ 1-2 times a week
☐ 3-4 times a week
☐ 5 or more times a week

Has any doctor or other health care professional ever told you not to exercise? ☐ Yes ☐ No

Do you know of any reason why you should not exercise? ☐ Yes ☐ No

If you answered yes to either question, please explain:

___

___

___

How many meals do you typically eat out per week? ___________

Are the majority of these meals with family or friends? ☐ Yes ☐ No

Are they usually fast food (e.g., McDonald’s)? ☐ Yes ☐ No

Usually in cafeteria/restaurant? ☐ Yes ☐ No

LIFESTYLE AND EATING HABITS (CONT.)

Of the following, check all the items that you feel help explain or describe your eating habits:

- □ Thinking about food too much of the time
- □ Eating high-fat foods
- □ Eating too many sweet foods
- □ Eating too quickly
- □ Uncontrollable binges
- □ Eating in reaction to tension and depression
- □ Overeating when alone
- □ Using food as a reward
- □ Eating to take my mind off other problems
- □ Not paying attention to what I'm eating
- □ Overeating at social events
- □ Lack of satisfaction in life
- □ Eating in reaction to boredom
- □ Other (explain) ____

____

____

Are you allergic to

Cocoa?	□ Yes	□ No
Milk protein?	□ Yes	□ No
Corn?	□ Yes	□ No
Soy?	□ Yes	□ No
Eggs?	□ Yes	□ No

Other food? (describe) ___________________________________

Are you sensitive to or do you have a problem with

Aspartame (Nutrasweet)?	□ Yes	□ No
Monosodium glutamate (MSG)?	□ Yes	□ No
Lactose? (unable to drink milk but able to eat cheese and yogurt)	□ Yes	□ No

Do you smoke?	□ Yes	□ No
Any current or past drug use?	□ Yes	□ No

Surgical History

Please list ALL surgical procedures you have undergone:

Date of Admission	Length of Stay	Surgery

Family History

Please list all medical conditions that run in your family:

Mother: ____

____

Father: ____

____

Siblings: ____

____

Number of Obese Family Members _______

I certify that the information on this form is true and correct to the best of my knowledge.

____ ________________________

Signature Date