MEDICAL WEIGHT LOSS PROGRAM

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http://www.highpointregional.com

Medical History Form

Please Print:

Patient Name: _____ Date of Birth: _____ Age: _____
Address: _____
City/State: _____ Zip Code: _____
Home Phone: _____Cell Ph:_____ Work Ph: _____
Email Address:_____
Social Security #: _____ Gender (circle one): Male Female
Emergency Contact: _____ Phone: _____ Relationship: _____
Marital Status (circle one): Single Married Divorced Widowed Separated
Employer: _____ Employment Status: _____
Employment Address: _____ Phone #: _____
Primary Care Doctor: _____ Phone #: _____
Race: _____ (Circle one): Hispanic/Non Hispanic
Spouse Name: _____ Date of Birth: _____
Spouse Employer: _____
Primary Insurance: _____
Policy Holder's Name: _____ Holder's Date of Birth: _____
Policy ID #: _____ Group #: _____
Policy Holder's Employer: _____
Secondary Insurance: _____ Holder's Date of Birth: _____
Policy ID #: _____ Group #: _____

Do you have anti-obesity medication coverage?_____ Please check all that apply:
□Saxenda □Qsymia □Contrave □Belviq □Phenteramine

Patient Signature: _____ Date: _____

□ I confirm that typing my name in the above text field will serve as my digital signature.

Patient Name: _____ **DOB:** _____

Social History:

Do you currently smoke? ❑ Yes ❑ No

If yes, how many years have you been smoking? _____ Packs per day? _____

For past smokers, what year did you quit? ____How many years did you smoke? ____

Do you drink alcohol? ❑ Yes ❑ No

If yes, how many times/week or month? _____

Do you use illicit/street drugs? ❑ Yes ❑ No

If yes, what type did/do you use and how often? _____

Do drink coffee/tea? ❑ Yes ❑ No

If yes, cups per day? _____

Do drink carbonated beverages? ❑ Yes ❑ No

If yes, can/cups per day? _____

Patient Name: _____ **DOB:** _____

Medical History:

Please carefully review the list of medical conditions/problems listed below. Check all that apply to you:

□Angina
□Allergic Rhinitis
□Anxiety
□Asthma
□Breast Cancer
□Heart Disease w/bypass surgery
□Heart Disease without bypass surgery
□Cardiomyopathy
□Carpal Tunnel Syndrome
□Chest pain with exertion/exercise
□Gallstones
□Chronic Back Pain
□Congestive Heart Failure
□Stroke
□DVT (Blood Clot)
□Degenerative Disk Disease
□Depression
□Type I Diabetes/Insulin Dep (controlled)
□Type I Diabetes/Insulin Dep (Uncontrolled)
□Type II Diabetes/Adult Onset (Controlled)
□Type II Diabetes/Adult Onset (Uncontrolled)
□Abnormal Uterine Bleeding
□Dysmenorrhea (Excessively painful menses)
□Shortness of breath with exertion/exercise
□Abnormally elevated liver function tests
□Fatigue
□Fatty liver (due to alcohol)

□Fatty liver (NOT related to alcohol)
□Fibrocystic breast disease
□Fibromyalgia
□Acid Reflux Disease/GERD
□Gestational Diabetes (diab w/pregnancy)
□Cancer
□Anorexia/Bulimia
□Glucose Intolerance
□Gout
□ Heartburn/Indigestion/GERD
□ Hemorrhoids
□ High Cholesterol
□ Hypertension (high blood pressure)
□ High triglycerides
□ Hypothyroidism (Underactive thyroid)
□ Infertility
□ Insomnia
□ Intermittent Claudication
□ Intertriginous Dermatitis (irritation of the skin folds)
□ Irritable Bowel Syndrome
□ Joint Pain
□ Menstrual Irregularity
□ Migraine Headaches
□ Myocardial Infarction (Heart Attack)
□ Swelling of the legs (edema)
□ Peripheral Vascular Disease
□ Stomach Ulcers
□ Polycystic Ovarian Syndrome (PCOS)
□ Pseudotumor Cerebrii
□ Pulmonary Embolus (blood clot to lungs)
□ Seasonal Allergies
□ Sleep Apnea
□ Sleeping Disorder
□ Stress Urinary Incontinence (leaking urine with cough/straining)
□ Thrombophlebitis
□ Urinary Urge Incontinence (can't hold urine)
□ Varicose Veins
□ Venous Insufficiency
□ Renal/Kidney Disease
□ Binge or Emotional Eating
□ Arthritis (please indicate type)

Patient Name: _____ **DOB:** _____

Surgical History:

Please list surgeries you have had or indicate if you have not had any.

❑ No prior surgeries

Example: Open Hysterectomy w/ovaries removed – 01/25/1999 – no complications

Please specify Laparoscopic or Open

Surgery Type	Date	Complications:

Please list your medical providers and their contact information:

Primary Care Provider:

_____

_____

Specialists:

_____

_____

Medications:

Please list below any and all medications/vitamins or herbal supplements you are currently taking.

Example: Lipitor 10mg one tablet daily at bedtime

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10. _____

❑ Not currently taking any medications

Patient Name: _____ **DOB:** _____

Pharmacy Information:

Preferred pharmacy: _____Phone:_____
Address: _____
Fax: _____

Family History:

(Please include only parents, grandparents, and siblings)

Illness/Medical Condition	Family Member
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

Please list any allergies/intolerances you have:

_____
_____

❑ No Known Allergies

Stress:

On a scale of 1 to 10 (1=low; 10=very high), what is your daily stress level? _____

Sleep:

How many hours of sleep do you average each night? _____
How well do you sleep at night?
□Soundly, without interruption
□Restless, constant waking up & not being able to get back to sleep?
□Wake up to use restroom and go right back to sleep

Patient Name: _____ **DOB:** _____

Approximate Weight History:

20 years ago: _____ 10 years ago: _____ 5 years ago: _____
2 years ago: _____ 1 year ago: _____ 6 months ago: _____
What was your lowest adult weight? _____
What was your highest adult weight? _____
What age were you at the onset of obesity? _____
Were you at a steady weight for 2 or more years? _ If so, what was that weight? _____
What is the reason(s) for your weight gain? _____
What is your goal weight? _____

Weight Loss Programs/Diets/Medications:

Maximum weight loss on any program: _____
Maximum length of program you were on: _____
Name of program you had maximum weight loss on: _____
Check all previous weight loss programs you have attempted:

- ❑ Weight Watchers
- ❑ Slimfast
- ❑ Optifast
- ❑ Phen-Fen
- ❑ Jenny Craig
- ❑ Nutrasystem
- ❑ Medifast
- ❑ Adkins
- ❑ Low Carb/High Protein
- ❑ South Beach
- ❑ Meal Replacement/Liquid Diet
- ❑ OTC Weight Loss Diet Pills
- ❑ Other Physician/Dietitian/Hospital supervised Programs: _____

_____
_____

Please leave information below blank: Staff will measure your height and weight when you come to our office.

Height: _____
Weight: _____
BMI: _____
Neck:____Waist: _____ Hips: _____ Thighs: _____ Upper Arms: _____

RDN Signature: _____ DATE: _____

Provider Signature: _____ DATE: _____

Patient Name: _____ **DOB:** _____

Nutrition History:

How often do you eat out (include all meals): _____

How often do you eat fast food: _____

How often do you eat home cooked meals: _____

Who usually plans meals: _____

Who usually cooks: _____

What kind of beverages do you consume during meals: _____

What kind of beverages do you consume during the day: _____

Who usually shops for groceries: _____

Do you use a shopping list: _____

Food Cravings: _____

Do you use sugar substitute: _____

What kinds of oils (cooking and spreads) do you use? _____

Are you hungry in the middle of the night: _____

What are your worst food habits: _____

Snack Habits: _____

Do you eat more when you are stressed: _____

Do you skip meals? If so, which ones: □ Breakfast □Lunch □Dinner

Typical breakfast: _____

Typical lunch: _____

Typical Dinner:_____

What reasons do you feel contribute to your being overweight: _____

_____How active are you each day & what activities keep you active:_____

_____

What hobbies do you have that are important to you: _____

Patient Signature: _____ **Date:** _____

I confirm that typing my name in the above text field will serve as my digital signature.