MEDICAL WEIGHT LOSS at Avery Ranch

PLEASE PRINT LEGIBLY

Patient Information

Patients Name: _____ **Date of Birth:** _____ **Sex:** _____

Patients Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email: _____ **SSN:** _____

Employer: _____ **Occupation:** _____

Marital Status: _____ **Employed:** Full Time Part Time Retired

Emergency Contact: _____ **Contact Number:** _____

Pharmacy: _____ **Phone:** _____

Primary Care Physican: _____ **Contact Number:** _____

Signature of Patient/Guardian: _____ **Date:** _____

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Patients Name: _____ **Date:** _____

Personal Medical History: **Do you have or have you ever had Check all that apply.**

Cardiovascular	Yes	No	Unknown
Heart Disease			
MI (Heart Attack)			
Abnormal EKG			
High Blood Pressure			
Respiratory	**Yes**	**No**	**Unknown**
Asthma			
Shortness of breath?			
How far can you walk before getting short of breath?			
Is it getting worse?			
Sleep Disorder			
Sleep Apnea			
Do you use a C-PAP?			
Psychological	**Yes**	**No**	**Unknown**
Depression			
Panic Attacks			
Anxiety			
Bi-polar Disease			
Obsessive Compulive Disease			
Anorexia			
Bulimia			
Binge Eathing Disorder			
Neurological	**Yes**	**No**	**Unknown**
Headaches			
Medications:			
Endocrine	**Yes**	**No**	**Unknown**
Diabetic			
Average daily blood sugars:			
Do you have a thyroid problem?			
Elevated Cholesterol			

Urinary	Yes	No	Unknown
Difficulty with urination?			
Frequent bladder infections?			
Incontinence			
Constipation			
Kidney Infections			
Gynecological	**Yes**	**No**	**Unknown**
Still having menstraul cycle?			
Duration:			
Regular:			
Pain Associated:			
Date of Last Menstrual Period:			
Pregnancies			
Number:			
Natural or C-Section:			
Are you taking hormones/birth control/ HRT?			
Date of last check up:			
Musculoskeletal	**Yes**	**No**	**Unknown**
Back Pain			
Hip Pain			
Knee Pain			
Swelling of Feet			
Ankle/Foot Pain			
Other	**Yes**	**No**	**Unknown**
Glaucoma			
Antibiotic resistant organisms			
Hepatitis			
Drug Dependency			
Alcohol Dependency			

Past Medical History: Check all that apply

_____ Polio	_____ Scarlet Fever	_____ Pleurisy
_____ Jaundice	_____ Whooping Cough	_____ Liver disease
_____ Kidneys	_____ Bleeding Disorder	_____ Chicken Pox
_____ Lung Disease	_____ Tuberculosis	_____ Thyroid Disease
_____ Rheumatic Fever	_____ Pneumonia	_____ Heart Disease
_____ Ulcers	_____ Heart Valve Disorder	_____ Psychiatric Illness
_____ Anemia	_____ Gallbladder Disorder	_____ Alcohol Abuse
_____ Gout	_____ Eating Disorder	_____ Typhoid Fever
_____ Cancer	_____ Malaria	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Other: _____
_____ Measles	_____ Tonsillitis	_____ Other: _____
_____ Mumps	_____ Nervous Breakdown	_____ Other: _____

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Patients Name: _____ **Date:** _____

Review of Symptoms: Have you ever had any of the conditions below? If so, please check ALL applicable boxes below

General:

Yes	No	
☐	☐	Fatigue
☐	☐	Weight Gain
☐	☐	Weight Loss

Eyes/Ears/Nose/Throat/Mouth:

Yes	No	
☐	☐	Headache
☐	☐	Blurred Vision
☐	☐	Eye Pain
☐	☐	Hearing Loss
☐	☐	Glaucoma

Neck:

Yes	No	
☐	☐	Neck Mass
☐	☐	Swollen Glands

Respiratory:

Yes	No	
☐	☐	Chronic cough
☐	☐	Difficulty Breathing
☐	☐	Snoring
☐	☐	Wheezing

Immunologic:

Yes	No	
☐	☐	HIV / AIDS
☐	☐	Hepatitis (A,B, or C)

Cardiovascular:

Yes	No	
☐	☐	Calf Cramps
☐	☐	Chest Pain
☐	☐	Difficulty Breathing Lying Down
☐	☐	Elevated Blood Pressure
☐	☐	Fainting
☐	☐	Heart Attack
☐	☐	Irregular Heart Beat
☐	☐	Leg Pain / Swelling
☐	☐	Palpitations
☐	☐	Rapid Heart Rate

Date of Occurance: _____

☐	☐	Varicose Veins

Musculoskeletal:

Yes	No	
☐	☐	Back Ache
☐	☐	Joint Pain
☐	☐	Joint Swelling
☐	☐	Leg Cramps
☐	☐	Muscle Cramps
☐	☐	Muscle Weakness
☐	☐	Swelling to Extremities

Endocrine:

Yes	No	
☐	☐	Appetite Changes
☐	☐	Excessive Thirst
☐	☐	Excessive Urination
☐	☐	Heat Intolerance
☐	☐	Thyroid Problem

Gastrointestional:

Yes	No	
☐	☐	Abdominal
☐	☐	Bloating
☐	☐	Black, Tarry Stool
☐	☐	Bloody Stool
☐	☐	Constipation
☐	☐	Hemorhoids
☐	☐	Heartburn
☐	☐	Nausea

Physchiatric:

Yes	No	
☐	☐	Anxiety/ Panic Attacks
☐	☐	Depression
☐	☐	Hallucinations
☐	☐	Insomnia

Neurological:

Yes	No	
☐	☐	Decreased Memory
☐	☐	Numbness
☐	☐	Headaches
☐	☐	Seizures
☐	☐	Stroke
☐	☐	Visual changes
☐	☐	Weakness

Allergies:

Are you allergic to any medications? **YES or NO** If so, please list mediation and reaction

Medicaton	Reaction

Prescription Medication:

Medication Name	Dose	Frequency

Non-Prescription Medication

Medication Name	Dose	Frequency

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Dieting History:

Age you first started dieting: _____ Approximate weight at 18 yrs _____

Current Height: _____ Current Weight _____ Goal Weight: _____

Weight Range last 5 yrs: _____ to _____

Program	Yes	No	Dates		Duration	Max Weight Loss	MD Supervised? Y or N
Jenny Craig							
Nutri-System							
Weight Watchers							
Opti-fast / Medi Fast							
O.A or TOPS							
Fen/Phen							
Meridia							
Xenical							
Over the counter Diet Aids							
Atkinds Diet							
South Beach Diet							
Other:							
Other:							
Other:							
Other:							
Other:							
Other:							
Other:							

What was the most successful wiegth loss you have achieved and how did you do it?

What behaviors did you learn from dieting that you still use today?

Food Preference:

Are you a sweet eater? Yes or NO If yes, What? _____
How Often? _____

Are you a bread/pasta eater? Yes or NO If yes, What? _____
How Often? _____

Do you eat fast food? Yes or NO If yes, What? _____
How Often? _____

Do you snak between meals? Yes or NO If yes, What? _____
How Often? _____

Is snacking from habit? Yes or No Boredom? Yes or No Do you binge eat? Yes or No

What beverages do you consume throughout the day and qty? _____

Social / Family History:

Is there obesity in your family? Yes or NO Who?_____
Have you been overweight all your life? Yes or NO If not, how long? _____
Do you exercise regularly? Yes or NO How often? _____
Any problems with exercise? _____
Any previous prescription weight loss medication? _____
What would your like your weight to be? _____ At what age were you last at this weight? _____
Have you been or are you being treated for alcohol or other substance abuse / dependence? _____
Do you drink alcohol? Yes or NO How many drinks / week? _____
Do you smoke? Yes or NO How many packs? _____
Any family history of the following:

Heart Disease	Yes	or	NO	Who?_____
Stroke	Yes	or	NO	Who?_____
Diabeties	Yes	or	NO	Who?_____
Cancer	Yes	or	NO	Who?_____
High Choleserol	Yes	or	NO	Who?_____
Obesity	Yes	or	NO	Who?_____
Glaucoma	Yes	or	NO	Who?_____
Asthma	Yes	or	NO	Who?_____
Epilepsy	Yes	or	NO	Who?_____
High Blood Pressure	Yes	or	NO	Who?_____
Kidney Disease	Yes	or	NO	Who?_____
Psychiatric Disorder	Yes	or	NO	Who?_____
Sudden Death	Yes	or	NO	Who?_____

Please list any other serious illnesses you have had:

Illness	Date	Treatment