Patient History Form

DATE: _______________

Last Name: ____________________________ **First Name**: _______________________ **Phone** ______________

Address: ____ **City**: _______________ **Zip**: _____________

Primary Care Physician: _________________________ **Allergies: ____________________________________**

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Current Medications: ____

Current Health Problems: ____

Major Events/Hospitalizations/Surgeries: ____

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Are you pregnant, trying to become pregnant, or breastfeeding? _____________________________________

Other weight loss programs attempted:

Weight Watchers	Jenny Craig	LA weight loss	PHC	Medifast
Nutrisystem	Slim fast	Atkins		

Other Medications used to help you lose weight: ____

Past Medical History/ Family History

	Self	Mother	Father	Other		Self	Mother	Father	Other
High blood pressure					Shortness of breath				
Heart disease					Diabetes				
Heart attack					Abdominal pain				
Leg swelling					Anemia/bleeding problem				
Headaches					Depression/anxiety				
Glaucoma/cataract					Cancer				
Thyroid problems									

Social History

	Self	Frequency
Tobacco use		
Alcohol use		
Illegal drug		

Review of systems: Check all that YOU have experienced within the last 12 months.

	WEIGHT GAIN/LOSS		FEVER		FATIGUE		DIZZINESS		VISION CHANGE
	NOSE BLEEDS		SINUS PROBLEMS		HEARING CHANGE		LIGHT HEADED		IRREGULAR HEARTBEAT
	CHRONIC COUGH		WHEEZING		DIFFICULTY BREATHING		COUGHING UP BLOOD		HEARTBURN / INDIGESTION
	ULCERS		DIARRHEA		CONSTIPATION		NAUSEA AND VONITING		GAS
	BLACK STOOLS		FREQUENT URINATION		PAINFUL URINATION		BLOOD IN URINE		DIFFICULTY VOIDING
	ABNORMAL/PAINFUL PERIODS		ABDOMINAL VAGINAL BLEEDING		MUSCLE/ JOINT PAIN		MUSCLE WEAKNESS		RASH
	SKIN ULCERS		DRY SKIN		NON- HEALING WOUNDS		BREAST PAIN		BREAST DISCHARGE
	SEIZURES		NUMBNESS		MEMORY LOSS		TROUBLE WALKING		DEPRESSION
	ANXIETY		SADNESS		HEAD COLD		INFERTILITY		HAIR LOSS
	HOT FLASHES		EASILY BLEEDING		BRUISES		SWOLLEN GLANDS		OTHER

REVIEWED _______ DATE______