# A gold logo with a black background Description automatically generated

# Patient History Form Date:\_\_\_\_\_\_\_\_\_\_\_

*Please complete this form to the best of your ability. The doctor will review your answers during your visit*

|  |
| --- |
| Last Name First Middle Date of Birth Age M / F |
| Primary Care Doctor Office Number Last Physical Exam |
| Height Weight *For Weight Loss Patients:* Goal Weight Lowest Adult Weight (after age 18) |
| Main Reason for Visit REFERRED BY: |

# MEDICAL & FAMILY HISTORY

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | S  e  l  f | F  a  m  i  l  y |  | S  e  l  f | F  a  m  i  l  y |  | S  e  l  f | F  a  m  i  l  y |
| Seizures |  |  | Asthma / COPD |  |  | Diarrhea |  |  |
| Migraines or Headaches |  |  | Sleep Apnea |  |  | Liver Disease |  |  |
| Dizziness |  |  | Pulmonary Hypertension |  |  | Gallbladder Disease/ Stones |  |  |
| Loss of Consciousness |  |  | Shortness of Breath |  |  | Ulcers |  |  |
| Stroke |  |  | Irregular Heart Rhythm |  |  | Colitis |  |  |
| Glaucoma |  |  | Heart Attack or Angina |  |  | Constipation |  |  |
| Thyroid Disorder |  |  | Palpations |  |  | Arthritis |  |  |
| Obesity / Overweight |  |  | Heart Valve Disorder |  |  | Gout |  |  |
| Diabetes Mellitus (DM) |  |  | Heart Failure (CHF) |  |  | Osteopenia or Osteoporisis |  |  |
| High Blood Sugar |  |  | High Blood Pressure |  |  | Kidney Disease or Stones |  |  |
| Abnormal Cholesterol |  |  | Rheumatic Fever |  |  | Alcohol Abuse |  |  |
| Insomnia |  |  | Tuberculosis |  |  | Drug Abuse |  |  |
| Dementia |  |  | HIV |  |  | Eating Disorder |  |  |
| Pancreatis |  |  | Caner:(type): |  |  | Depression or Anxiety |  |  |
| Other | |  |  |  |  |  |  |  |

*MD Notes:*

# SURGERIES & HOSPITALIZATIONS

|  |  |
| --- | --- |
| Reason / Diagnosis | **Year** |
|  |  |
|  |  |

# SPECIALISTS (If Any)

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |

# MEDICATION ALLERGIES *No Known Allergies*

|  |  |
| --- | --- |
| Name of Medication | Reaction |
|  |  |
|  |  |
|  |  |

## PRESCRIPTION MEDICATIONS

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dose & Frequency | Approx Start Date | Reason for Use |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## SUPPLEMENTS & OVER THE COUNTER MEDICATIONS

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dose & Frequency | Approx Start Date | Reason for Use |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

## SCREENINGS & TESTINGS

|  |  |  |
| --- | --- | --- |
| TEST | Last Date Done | Results *(-) or State Findings* |
| Blood Sugar, Cholesterol |  |  |
| Colonoscopy |  |  |
| PAP Smear (women) |  |  |
| Prostate Exam, PSA (men) |  |  |
| Cardiac Testing (EKG, echo, stress, etc) |  |  |
| Trans-vaginal Ultrasound |  |  |
| Mammography |  |  |
|  |  |  |
|  |  |  |

***FEMALE*** *patients: Please check all that apply*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| Sleep Disorder |  |  |  |  |
| Anxiety /Nervousness |  |  |  |  |
| Irritability |  |  |  |  |
| Depression / Emotional Swings |  |  |  |  |
| Food Cravings |  |  |  |  |
| Hot Flashes |  |  |  |  |
| Night Sweats |  |  |  |  |
| Vaginal Dryness |  |  |  |  |
| Urine Leakage |  |  |  |  |
| Dry Skin /Wrinkles |  |  |  |  |
| Dry Hair |  |  |  |  |
| Fatigue |  |  |  |  |
| Memory Loss |  |  |  |  |
| Concentration Loss |  |  |  |  |
| Hair Loss |  |  |  |  |
| Loss of Libido / Orgasm |  |  |  |  |
| Muscle Weakness / Loss |  |  |  |  |
| Muscle and Joint Pain |  |  |  |  |
| Loss of Pubic Hair |  |  |  |  |

***MALE*** *patients: Please check all that apply*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **NONE** | **MILD** | **MODERATE** | **SEVERE** |
| Dry Skin |  |  |  |  |
| Dry Hair |  |  |  |  |
| Sleep Disorder |  |  |  |  |
| Fatigue |  |  |  |  |
| Memory Loss |  |  |  |  |
| Concentration Loss |  |  |  |  |
| Anxiety / Nervousness |  |  |  |  |
| Irritability |  |  |  |  |
| Depression |  |  |  |  |
| Loss of Libido / Orgasm |  |  |  |  |
| Difficulty Achieving Erection |  |  |  |  |
| Difficulty Maintaining Erection |  |  |  |  |
| Premature Ejaculation |  |  |  |  |
| Muscle Weakness |  |  |  |  |
| Muscle Loss |  |  |  |  |
| Muscle and Joint Pain |  |  |  |  |
| Loss of Masculinity / Confidence / Aggressiveness |  |  |  |  |

## OB/GYN HISTORY (Female Patients)

|  |
| --- |
| Last Menstrual Period: Age at First Onset of Period: |
| If still menstruating: cycle \_\_\_\_\_\_\_days Circle if (+): Heavy Periods, Irregularity, Spotting or Pain |
| Are you pregnant: NO YES Are you breastfeeding: NO YES Are you trying for a pregnancy: NO YES |
| Number of Pregnancies: Living children:\_\_\_\_\_\_ Vaginal \_\_\_\_\_ C-Section \_\_\_\_\_ Abortions \_\_\_\_ Miscarriages\_\_\_\_ |
| History of Sexual Abuse: NO YES |

## PERSONAL & SOCIAL HISTORY

|  |  |  |
| --- | --- | --- |
| Occupation: Stress Level (0-10): | | |
| Marital Status: Do you feel safe in your relationship  # Living Children\_\_\_\_\_\_\_ YES NO | | |
| Use of Alcohol If YES, what kind: How many drinks / week:  **NO YES** | | |
| Tobacco: If YES, number of years total\_\_\_\_\_\_\_\_ Past use / Quit Date:\_\_\_\_\_\_\_\_\_\_\_\_  **NO YES** Cigarettes packs/day \_\_\_\_\_\_ Cigars/day \_\_\_\_\_\_\_\_ Chew/day\_\_\_\_\_\_\_\_ Pipe/day\_\_\_\_\_\_ | | |
| Recreational or Street Drugs use:  **NO YES** If YES, have you ever taken street drugs with a needle: **NO YES** | | |
| Sexually Active Heterosexual Contraception:  Bi-sexual Current Method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  NO YES Homosexual Past Method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Hobbies / Interests: | | |
| **REVIEW OF SYSTEMS**  *Please check YES to any symptoms that you experience. For any YES answer please provide a brief description* | | |
|  | YES | If YES, **list doctor seen**, describe condition and how long |
| Fever /Chills |  |  |
| Excess Fatigue |  |  |
| Weight loss / gain |  |  |
| Enlarged lymph nodes |  |  |
| Frequent bruising |  |  |
| Blurry Vision |  |  |
| Ringing in Ears |  |  |
| Hearing difficulty |  |  |
| Mouth Sores |  |  |
| Sinus Problems |  |  |
| **Cardiovascular:** | | |
| Chest pain at rest or exercise |  |  |
| Cold hands / cold feet |  |  |
| Swelling of legs |  |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal YES** | | |
| Constipation |  | # bowel movement / day\_\_\_\_\_\_\_ |
| Diarrhea |  |  |
| Bloating |  |  |
| Excessive Belching |  |  |
| Gas / Acidity |  |  |
| Blood in Stool |  |  |
| Thirst: Lack of / too much |  | # of glasses of fluid /day\_\_\_\_\_\_\_ |
| **Genitourinary** | | |
| Pain on urination |  |  |
| Cloudy / Bloody Urination |  |  |
| Urinating too many times |  | # times per day\_\_\_\_\_\_\_ |
| Difficulty urinating |  |  |
| Loss of Urine |  |  |
| **Musculoskeletal: *If YES to any of following questions, please ask for a PAIN RATING scale.*** | | |
| Do you see a chiropractor? |  |  |
| Any regular body treatment /massage |  |  |
| Back Pain |  |  |
| Neck Pain |  |  |
| Shoulder Pain |  |  |
| Arm Pain |  |  |
| Hip Pain |  |  |
| Knee Pain |  |  |
| Other Pain |  |  |
| Muscle Point Tenderness (pls describe) |  |  |
| **Skin** | | |
| Acne |  |  |
| Dry Skin |  |  |
| Oily Skin |  |  |
| Loss of Collagen / Firmess |  |  |
| Wrinkles |  |  |
| Pigmentation / Scarring |  |  |
| Any History of Skin Cancer? |  |  |
| Do You Wear Sunblock? |  |  |
| After Sun Exposure, do you (circle): BURN Sometimes Burn Rarely Burn Never Burn Tan | | |
| Cellulite |  |  |
| Questions on aesthetic services: Botox, Juvederm, lasers? |  |  |
| Interest in Skin Care Consultation |  |  |
| **Emotional** | | |
| Do you see a counselor or psychiatrist |  |  |
| Depression |  |  |
| Anxiety |  |  |
| Stress |  |  |
|  |  |  |
|  |  |  |

***I have answered the above to the best of my abilities.***

**Patient Signature:**

# Nutrition Evaluation

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Vegetable Intake (pls circle): <10% 20-40% 41-60% >60% | | | | | | | |
| Number of meals per day: | | | | | | | |
| Snacks per day: What snacks & when: | | | | | | | |
| Food Allergies: | | | | | | | |
| Food Dislikes: | | | | | | | |
| Food(s) you Crave Any specific time of day /month you crave food? | | | | | | | |
| Do you awaken hungry during the night? If yes, what do you do?  YES NO | | | | | | | |
| Behavior Style (check only one):  \_\_\_\_Always clam & easy going \_\_\_\_Seldom calm and persistently driving for advancement  \_\_\_\_Usually calm & easy going \_\_\_\_Never calm and have overwhelming ambition  \_\_\_\_Sometimes calm with frequent impatience \_\_\_\_Hard-driving and can never relax | | | | | | | |
|  | NO | YES |  | | NO | YES | If not you, WHOM? |
| Partner or Spouse Overweight? |  |  | I plan my meals | |  |  |  |
| By how much\_\_\_\_\_\_\_lbs |  |  | I cook my meals | |  |  |  |
| I eat out daily |  |  | I shop for food | |  |  |  |
| I eat our \_\_\_\_\_\_\_ times / week |  |  | I use a shopping list for grocery | |  |  |  |
| I eat “fast foods” daily |  |  | Time of day I usually shop: | |  |  |  |
| I eat “fast foods” \_\_\_\_\_\_\_times / week |  |  | I use sugar substitute | |  |  |  |
| I drink cola drinks |  |  | I use butter | |  |  |  |
| I eat when I am stressed |  |  | I use margarine | |  |  |  |
| I am currently stressed |  |  | I drink coffee or tea  How many cups/day:\_\_\_\_\_ | |  |  |  |
| I skip meals |  |  | I eat on behalf of someone else | |  |  |  |
| ***If Weight Loss is an aim for you, please answer the following questions.*** | | | | | | | |
| Goal Weight: In what time frame would you like to be at your goal weight: | | | | | | | |
| Birth Weight: Weight one year ago: | | | | | | | |
| Highest Weight (non-pregnant) and when: Lowest Adult Weight(>18): | | | | | | | |
| Main Reason for you decision to lose weight: | | | | | | | |
| When did you begin gaining excess weight? (Give Reasons, if known) | | | | | | | |
| Previous Diets Followed | | | | Approximate Date & Results of Weight Loss | | | |
|  | | | |  | | | |
|  | | | |  | | | |
|  | | | |  | | | |
|  | | | |  | | | |
|  | | | |  | | | |

|  |  |  |
| --- | --- | --- |
| Typical Breakfast | Typical Lunch | Typical Dinner |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Time Eaten:\_\_\_\_\_\_\_\_\_\_\_\_ Time Eaten:\_\_\_\_\_\_\_\_\_\_\_\_ Time Eaten:\_\_\_\_\_\_\_\_\_\_\_\_

Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With Whom:\_\_\_\_\_\_\_\_\_\_\_\_ With Whom:\_\_\_\_\_\_\_\_\_\_\_\_ With Whom:\_\_\_\_\_\_\_\_\_\_\_\_

Activity Level: **(check only one):**

Inactive: no regular physical activity with a sit-down job.

Light activity: no organized physical activity during leisure time

Moderate activity: occasionally involved in activities such as weekend golf, tennis jogging, swimming or cycling Heavy activity: consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week

Vigorous activity: participation in extensive physical exercise for at least 60 minutes per session ≥ 4 times per week.

Please describe you general health goals and improvements you wish to make:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and practice in completing this form.*

Additional NOTES:

**Patient Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_