WEIGHT NO MORE
NEW PATIENT MEDICAL HISTORY FORM

Name: (First)______________________________ (Last) ______________________________ (MI)____
Date of Birth: _____/_____/__________ Date of Visit: _____/_____/__________
Phone: (Home/Cell) _______________________ (Work) _______________________ Gender: M / F
Referred By: ______________________________

How does your weight affect your life and health? ____
____
____

Weight History

When did you become overweight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _________
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _______________________

What was your maximum weight loss? ____
What are your greatest challenges with dieting? ____
____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: _______________________
What worked? ____
What didn't work? ____
Why or why not? ____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____

Nutritional History Continued

Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____

Eating triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out

☐ Fast Food ☐ Other: _______________________

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions

Favorite foods: ____

Medical History

Exercise type: ____

Duration: _____ hours _____ minutes Number of times per week: _____

What prevents you from exercising? ____

How many hours do you sleep per night? _____ How times do you get up during the night? _____

Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gall bladder stones ☐ Sleep apnea

☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux arthritis ☐ Thyroid

☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety

☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression

☐ Infertility ☐ Polycystic Ovarian Syndrome

☐ Cancer (type/s): ____

Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? __________________

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass

☐ Hysterectomy ☐ Other: ____

Medications (list all current medications and dosages):

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

Allergies:

(Medications)____

(Food)____

Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ yrs ago)

Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: ______________________

Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol

☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression

☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): ____

Other: ________________________

Gynecologic History

Age periods started _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds

☐ Recent weight gain more than 10 pounds

☐ Acne
☐ Snoring
☐ Difficulty breathing when flat
☐ Swelling ankles/extremities
☐ Constipation
☐ Dysphagia/difficulty swallowing
☐ Increased appetite
☐ Gas and bloating
☐ Nighttime urination
☐ Back pain (upper)
☐ Muscle aches/pain
☐ Seizures
☐ Depression
☐ Inability to concentrate
☐ Loss of interest
☐ Hair changes
☐ Fatigue/tiredness

☐ Skin rash
☐ Shortness of breath
☐ Fainting/Blacking out
☐ Abdominal pain
☐ Diarrhea
☐ Indigestion
☐ Decreased appetite
☐ Urinary frequency/urgency
☐ Loss of urine control
☐ Back pain (lower)
☐ Dizziness
☐ Weakness/low energy
☐ Insomnia
☐ Mood changes
☐ Cold intolerance
☐ Heat intolerance

☐ Cough
☐ Chest pain
☐ Palpitations
☐ Bloating
☐ Food intolerance
☐ Nausea/vomiting
☐ Heartburn
☐ Slow urine flow
☐ Blood in stools
☐ Joint pain
☐ Headaches
☐ Anxiety
☐ Memory loss
☐ Nervousness
☐ Excessive sweating
☐ Blood clots

(Men only)

☐ Difficulty with erections ☐ Loss of interest in sex ☐ Low testosterone

(Women only)

☐ Absence of periods
☐ Abnormal/excessive menstruation
☐ Difficulty getting pregnant

☐ Hot flashes
☐ Facial hair

☐ Change in bladder habits
☐ Loss of interest in sex

Comments: ____