OGDENCLINIC
MEDICAL WEIGHT LOSS

PATIENT MEDICAL HISTORY FORM

(for anything that does not apply to you, please put N/A)

Name: _____ **Date:** _____

Age: _____ **Sex:** ❑ M ❑ F **DOB:** _____

1. How did you hear about our program? _____

Who referred you to our program? _____

Who is your primary care provider? _____

SLEEP QUESTIONS

2. a. Do you have a history of sleep apnea? ❑ Yes ❑ No

If yes, treatment/managing provider: _____

b. Do you snore? ❑ Yes ❑ No

c. Do you feel rested upon waking up? ❑ Yes ❑ No

d. What is your usual energy level on a scale of 1-10? *(1 = no energy, 10 = full energy)*

1 2 3 4 5 6 7 8 9 10

e. How many times do you wake up during the night? _____

f. Do you use any supplemental sleep therapy at night? _____

g. Does the urge to urinate frequently wake you up? ❑ Yes ❑ No

If yes, how many times per night? _____

h. Average bed time: _____ Average time out of bed: _____

i. How long on average does it take you to fall asleep? _____

CURRENT EXERCISE

3. a. Activity Level: *(answer only one)*

❑ Inactive *(no regular physical activity)*

❑ Light Activity *(no organized physical activity during leisure time)*

❑ Moderate Activity *(occasional activities such as weekend golf, tennis, jogging, swimming, or cycling)*

❑ Heavy Activity *(lifting, heavy construction or participation in physical exercise least 3 times weekly)*

❑ Vigorous Activity *(extensive physical exercise for at least 60 minutes per session, 4 times per week)*

4. What are some barriers that inhibit your ability to change? _____

_____

_____

OB/GYN HISTORY

5. a. Have you had any pregnancies? ❑ Yes ❑ No

If yes, how many? _____ Dates: _____

Any problems during pregnancy? ❑ Yes ❑ No

Any difficulty getting pregnant? ❑ Yes ❑ No

Any diagnosis of infertility? ❑ Yes ❑ No

Did you gain more than 40 lbs. with pregnancy? ❑ Yes ❑ No

Did you have a baby weighing 8 lbs. or more at birth? ❑ Yes ❑ No

b. Age of first menstrual cycle: _____

c. Are your menstrual cycles heavy? ❑ Yes ❑ No

d. Are your menstrual cycles regular? ❑ Yes ❑ No

e. Is there pain associated with your menstrual cycles? ❑ Yes ❑ No

f. What is your current form of contraceptive? _____

MEDICAL HISTORY

6. a. Are you under a doctor's care presently? ❑ Yes ❑ No

If yes, for what? _____

_____

b. Past Medical History *(check all that apply)*

❑ Alcohol Abuse	❑ Gallbladder Disorder	❑ Lung Disease
❑ Anemia	❑ Gout	❑ Osteoporosis/penia
❑ Arthritis	❑ Heart Valve Disorder	❑ Psychiatric Illness
❑ Bleeding Disorder	❑ Jaundice	❑ Thyroid Disease
❑ Cancer	❑ Kidney Disease	❑ Ulcers
❑ Eating Disorder	❑ Liver Disease	❑ Other: _____

c. Are you taking any medications? ❑ Yes ❑ No

Prescription Drugs: *(list all)*

Drug: _____ Dose: _____

Drug: _____ Dose: _____

Over-The-Counter Medications, Vitamins and Supplements: *(list all)*

Product: _____ Dose: _____

Product: _____ Dose: _____

d. History of High Blood Pressure? ❑ Yes ❑ No

e. History of Diabetes? ❑ Yes ❑ No

If yes, at what age? _____

What type? ❑ Type I ❑ Type II ❑ Gestational

f. History of heart attack, chest pain, or other heart condition? ❑ Yes ❑ No

g. History of frequent headaches? ❑ Yes ❑ No

History of migraines? ❑ Yes ❑ No

h. History of constipation? *(difficulty in bowel movements?)* ❑ Yes ❑ No

i. History of Glaucoma? ❑ Yes ❑ No

j. Have you had any of the following? *(check all that apply?)*

❑ Acne ❑ Dermatitis/Eczema/Skin Condition

❑ Skin tags ❑ Abnormal facial hair growth

❑ Areas of dark skin behind neck, armpits, under breasts, around waist or groin.

k. Do you have any known allergies to medications? ❑ Yes ❑ No

If yes, please list the medication and the reaction: _____

_____

SURGICAL HISTORY

7. a. Have you had any surgeries? ❑ Yes ❑ No

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

b. Have you had any over-night hospital visits? ❑ Yes ❑ No

Reason: _____ Date: _____

Reason: _____ Date: _____

Reason: _____ Date: _____

FAMILY HISTORY

8. a. Please list age, health, disease, if overweight and cause of death for each relative:

Father: _____

Mother: _____

Brother(s): _____

Sister(s): _____

b. Has any blood relative ever had any of the following? *If yes, who? (clarify paternal/maternal)*

Glaucoma	❑ Yes	❑ No	Who: _____
Asthma:	❑ Yes	❑ No	Who: _____
Epilepsy:	❑ Yes	❑ No	Who: _____
High Blood Pressure:	❑ Yes	❑ No	Who: _____
Kidney Disease:	❑ Yes	❑ No	Who: _____
Diabetes:	❑ Yes	❑ No	Who: _____
Psychiatric Disorder:	❑ Yes	❑ No	Who: _____
Heart Disease/Stroke:	❑ Yes	❑ No	Who: _____
Obesity:	❑ Yes	❑ No	Who: _____
Cancer:	❑ Yes	❑ No	Who: _____

9. a. Do you smoke? *(cigarettes, cigars, e-cigs)* ❑ Yes ❑ No

b. If yes, are you interested in quitting? ❑ Yes ❑ No

NUTRITIONAL EVALUATION

10. a. Present weight: _____ Height (no shoes): _____ Desired Weight: _____

b. In what time frame would you like to meet your desired weight? _____

c. Birth weight: _____ Weight at 20 years old: _____ Weight one year ago: _____

d. What is the main reason for your decision to lose weight? _____

_____

e. When did you begin to gain excess weight? (give reasons if known): _____

_____

f. What has been your maximum lifetime weight (non-pregnant) and when? _____

_____

g. Previous diets you have followed: *(give dates and results)* _____

_____

_____

g. Previous diets you have followed: *(give dates and results)*

h. Previous medications (for weight loss) you have tried: *(give dates and results)*

i. Is your spouse, fiancée, or partner over weight? ❑ Yes ❑ No

j. Are they supportive about you losing weight? ❑ Yes ❑ No

Describe:

k. Do you have a support system? ❑ Yes ❑ No

l. How often do you eat out per week? <1 2-3 4-7 8-12 >12

m. Who plans meals? Cooks? Shops?

n. Any food allergies?

o. Any food dislikes?

p. Do you crave any foods?

q. Any specific time of day or month that you crave?

r. Do you drink soda? ❑ Yes ❑ No

If yes: ❑ Regular ❑ Diet ❑ Zero sugar

How much daily?

s. Do you drink alcohol? ❑ Yes ❑ No

If yes, what kind?

How much daily?

Weekly?

t. Do you use a sugar substitute? ❑ Yes ❑ No

If yes, what?

u. Do you awaken hungry during the night? ❑ Yes ❑ No

If yes, what do you do?

v. Snack Habits:

What:

When:

How much:

w. Do you experience any of these eating behaviors? *(check all that apply)*

- ❑ Binge Eating
- ❑ Boredom Eating
- ❑ Emotional Eating
- ❑ Skipping Meals on a Regular Basis
- ❑ Stress Eating
- ❑ Other: _____

BEHAVIOR STYLE

11. What best describes you? *(check only one)*

- ❑ You are always calm and easy going
- ❑ You are usually calm and easy going
- ❑ You are sometimes calm and frequently impatient
- ❑ You are seldom calm and persistently driving for advancement
- ❑ You are never calm and have overwhelming ambition
- ❑ You are hard-driving and can never relax

12. Please describe the general health goals and improvements you wish to make:

13. How ready are you to change? *(1 = no way, 10 = let's do it yesterday)*

1 2 3 4 5 6 7 8 9 10

14. How willing are you to change?

1 2 3 4 5 6 7 8 9 10

15. How able are you to change?

1 2 3 4 5 6 7 8 9 10

SCREENING QUESTIONS:

16. a. Do you have days of little interest or pleasure doing things?

❑ Never ❑ Some days ❑ Most days ❑ Every day

b. Do you have days of feeling down, depressed, and/or hopeless?

❑ Never ❑ Some days ❑ Most days ❑ Every day

17. Please use the space below to specify anything else you think we need to know about your current health:

_____

_____

_____

_____

_____