OGDENCLINIC
MEDICAL WEIGHT LOSS

Patient Medical History Form

Name: _____ **Date:** _____

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

Present Status:

1. Are you in good health at the present time to the best of your knowledge? ❑ Yes ❑ No

   If "no", explain: _____

2. Are you under a doctor's care at the present time? ❑ Yes ❑ No

   If yes, for what?: _____

3. Are you taking any medications at the present time? ❑ Yes ❑ No

   Prescription Drugs: (List all)

   Drug: _____ Dosage: _____

   _____ _____

   _____ _____

   Over-the-Counter medications, vitamins, supplements: List all: ❑ Yes ❑ No

   Product: _____ Dosage: _____

   _____ _____

   _____ _____

4. Any allergies to any medications? ❑ Yes ❑ No

   Please list: _____

5. History of High Blood Pressure? _____ ❑ Yes ❑ No

6. History of Diabetes? _____ ❑ Yes ❑ No

   At what age: _____

7. History of Heart Attack or Chest Pain or other heart condition? ❑ Yes ❑ No

8. History of Swelling Feet? ❑ Yes ❑ No

9. History of Frequent Headaches? ❑ Yes ❑ No

   Migraines? ❑ Yes ❑ No Medications for Headaches: _____

10. History of Constipation (difficulty in bowel movements)? ❑ Yes ❑ No

11. History of Glaucoma? ❑ Yes ❑ No

If yes: Treatment: _____ Managing Provider: _____

12. History of Sleep Apnea? ❑ Yes ❑ No

If yes: Treatment: _____ Managing Provider: _____

13. Have you ever had any of the following? (check all that apply)

- ❑ Acne
- ❑ Dermatitis/Eczema/Skin Condition
- ❑ Abnormal Facial Hair Growth
- ❑ Skin Tags
- ❑ Areas of dark skin behind neck, armpits, under breasts, around waist or around groin

14. Gynecologic History

Pregnancies: Number: _____ Dates: _____

Problems during pregnancies?: _____

Any difficulty getting pregnant? ❑ Yes ❑ No

If yes, any diagnosis of infertility? ❑ Yes ❑ No

If yes, diagnosing provider: _____ Year of diagnosis: _____

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

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

15. Menstrual:

Age of first cycle: _____

Are they heavy?: ❑ Yes ❑ No

Are they regular: ❑ Yes ❑ No

Pain associated: ❑ Yes ❑ No

Current form of contraceptive:

16. Surgeries: ❑ Yes ❑ No

Type: _____ Date: _____

_____ _____

_____ _____

17. Family History: (Please list: Age, Health, Disease, Cause of Death, Overweight?)

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

18. Has any blood relative ever had any of the following:

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: _____

Past Medical History: (check all that apply)

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

Nutrition Evaluation:

19. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

20. In what time frame would you like to be at your desired weight?: _____

21. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____

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

_____

23. When did you begin gaining excess weight? (Give reasons, if known): _____

_____

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

25. Previous diets you have followed: | Give dates and results of your weight loss:

_____ | _____

_____ | _____

_____ | _____

26. Previous medications you have tried: _____ Give dates and results: _____

_____ _____

_____ _____

_____ _____

_____ _____

27. Is your spouse, fiancée or partner overweight? ❑ Yes ❑ No

28. By how much is he or she overweight? _____

29. Are they supportive about you losing weight? ❑ Yes ❑ No Why? _____

30. Do you have a support system ❑ Yes ❑ No

31. Do you skip meals on a regular basis? ❑ Yes ❑ No ❑ Daily ❑ Weekly ❑ Rarely

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

33. What restaurants do you frequent? _____

34. Who plans meals? _____ Cooks? _____ Shops? _____

35. Food allergies: _____

36. Food dislikes: _____

37. Food(s) you crave: _____

38. Any specific time of the day or month do you crave food? _____

39. Do you drink coffee or tea? ❑ Yes ❑ No How much daily? _____

40. Do you drink cola drinks? ❑ Yes ❑ No How much daily? _____

41. Do you drink alcohol? ❑ Yes ❑ No

What? _____ How much daily? _____ Weekly? _____

42. Do you use a sugar substitute? ❑ Yes ❑ No ❑ Butter? ❑ Margarine?

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

What do you do? _____

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

What do you do? _____

45. What are your worst food habits? _____

46. Do you ever eat large volume of food in a short period of time? ❑ Yes ❑ No

If yes how often? _____

Do you feel distressed about your episode of excessive overeating? ❑ Yes ❑ No

47. Snack Habits:

What? _____ How much? _____ When? _____

48. When you are under a stressful situation at work or family related, do you tend to eat more? ❑ Yes ❑ No

Explain: _____

49. Smoking Habits: (answer only one)

_____ You have never smoked cigarettes, cigars or a pipe.

_____ You quit smoking _____ years ago and have not smoked since.

_____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.

_____ You smoke 20 cigarettes per day (1 pack).

_____ You smoke 30 cigarettes per day (1-1/2 packs).

_____ You smoke 40 cigarettes per day (2 packs).

_____ E-cigarettes

50. Describe your usual energy level: _____

51. How many hours of sleep do you normally get? ❑ 4 or less ❑ 5-6 ❑ 6-8 ❑ 8+

Do you feel rested after sleep? ❑ Yes ❑ No

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

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

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

Does the urge to urinate regularly wake you up? ❑ Yes ❑ No

If yes, how many times a night? _____

Do you snore? ❑ Yes ❑ No

Do you wake up with a headache or sore throat? ❑ Yes ❑ No

Do you toss and turn throughout the night? ❑ Yes ❑ No

Do you wake up rested? ❑ Yes ❑ No

55. Activity Level: (answer 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.

56. How many minutes of exercise per workout? _____

57. How many workouts per week? _____

58. What exercise activities are you doing? _____

59. What would you like to do? _____

60. Behavior style: (answer only one)

_____ You are *always* calm and easygoing.

_____ You are *usually* calm and easygoing.

_____ You are sometimes calm with frequent impatience.

_____ 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.

61. Please describe your general health goals and improvements you wish to make: _____

_____

62. How ready are you to change? 0 1 2 3 4 5 6 7 8 9 10 (0- No way, 10- let's do it yesterday)

63. How willing are you to change? 0 1 2 3 4 5 6 7 8 9 10

64. How able are you to change? 0 1 2 3 4 5 6 7 8 9 10

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

66. Do you have days of little interest or pleasure in doing things?

❑ Never ❑ Some Days ❑ Most Days ❑ Every Day

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

❑ Never ❑ Some Days ❑ Most Days ❑ Every Day

68. How did you hear about the program? _____

69. Who referred you to the program? _____

70. Who is your primary care provider? _____

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