OGDENCLINIC

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 ☐
   Explain a "no" answer: _____
   _____
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 ☐
12. History of Sleep Apnea? Yes ☐ No ☐

13. Gynecologic History:
Pregnancies: Number: _____ Dates: _____
Problems during pregnancies? _____
Natural Delivery or C-Section (specify): _____
Menstrual: Onset:
Duration:
Are they regular: Yes ☐ No ☐
Pain associated: Yes ☐ No ☐
Last menstrual period: _____

Hormone Replacement Therapy: Yes ☐ No ☐
What: _____

Birth Control Pills:
Type: _____

Last Check Up: _____

14. Serious Injuries:
Specify (list all) Date:

_____

_____

15. Any Surgery:
Specify: (List all) Date:

_____

_____

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

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

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: _____

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:

1. Present Weight:_____ Height (no shoes): _____ Desired Weight: _____
2. In what time frame would you like to be at your desired weight? _____
3. Birth Weight:_____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight?_____
   _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____
   _____
6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: | Give dates and results of your weight loss:
   _____ | _____
   _____ | _____
   _____ | _____
8. Is your spouse, fiancée or partner overweight? Yes ☐ No ☐
9. By how much is he or she overweight?_____
10. Are they supportive about you losing weight? Yes ☐ No ☐ Why?_____
11. Do you have a support system Yes ☐ No ☐
12. Do you skip meals on a regular basis? Yes ☐ No ☐ Daily ☐ Weekly ☐ Rarely ☐
13. How often do you eat out per week? <1 ☐ 2-3 ☐ 4-7 ☐ 8-12 ☐ > 12 (per week) ☐
14. What restaurants do you frequent? _____
15. How often do you eat "fast foods?" _____
16. Who plans meals? _____ Cooks? _____ Shops? _____
17. Do you use a shopping list? Yes ☐ No ☐

18. What time of day and on what day do you usually shop for groceries? _____

19. Food allergies: _____

20. Food dislikes: _____

21. Food(s) you crave: _____

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

22. Do you drink coffee or tea? Yes ☐ No ☐ How much daily? _____

23. Do you drink cola drinks? Yes ☐ No ☐ How much daily? _____

24. Do you drink alcohol? Yes ☐ No ☐

What? _____ How much daily? _____ Weekly? _____

25. Do you use a sugar substitute? Yes ☐ No ☐ Butter? ☐ Margarine? ☐

26. Do you awaken hungry during the night? Yes ☐ No ☐

What do you do? _____

27. What are your worst food habits?

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 ☐

28. Snack Habits:

What? _____ How much? _____ When? _____

29. When you are under a stressful situation at work or family related, do you tend to eat more?

Explain: _____

_____

30. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

_____

_____

31. 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

32. Typical Breakfast

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

Typical Lunch

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

Typical Dinner

_____
_____
_____
_____

Time eaten: _____
Where: _____
With whom: _____

33. Describe your usual energy level: _____

34. 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 ☐

35. 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.

36. 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.

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

_____

_____

38. 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)

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

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

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

_____

_____

43. How did you hear about the program? _____

44. Who referred you to the program? _____

45. Do you want your progress note sent to your primary care provider? Yes ☐ No ☐

PCP Name: _____

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.