SENTARA®

Sentara Comprehensive Weight Loss Solutions

www.sentaraweightloss.com

New Patient Medical History Form

Please answer all questions *completely* *before* your first office visit.
If your form is not completely filled out before your appointment, you will be rescheduled.

Name: ___________________________________ Age: _____Date of birth: ___________ Sex: M F

Present Status:

1. Who is your Primary Care Physician? ____

Address: ____

Physician's Office #____

2. Are you taking any medications at the present time? YES NO

Prescription Drugs:
(Please list **all medications**, including any "as needed" medications and birth control medicines)

Drug: Dosage: Frequency: (as needed, 2x/day, etc)

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Over-the-Counter medications, vitamins or supplements: YES NO

Product: Dosage: Frequency:

3. Please list all Current Medical Problems:

4. Are you allergic to any medications? YES NO

Please list medications and describe the reaction (For example, penicillin causes rash)

Review of Systems: (Are you CURRENTLY experiencing any of the following?)

General-
□ Fatigue □ Fever or chills □ Weakness □ Trouble sleeping

Skin-
□ Rashes □ Lumps □ Itching □ Dryness □ Color changes □ Hair and nail changes

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Head-
□ Headache □ Head injury

Ears-
□ Decreased hearing □ Ringing in ears (tinnitus) □ Earache □ Drainage

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Eyes-
□ Vision □ Glasses or contacts □ Pain □ Redness □ Blurry or double vision □ Flashing lights
□ Specks □ Glaucoma □ Cataracts □ Last eye exam___________________________________

Nose-
□ Stuffiness □ Discharge □ Hay fever □ Nosebleeds □ Sinus pain

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Throat-
□ Difficulty or painful swallowing □ Dentures □ Sore tongue □ Dry mouth □ Hoarseness

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Neck-
□ Lumps □ Swollen glands □ Pain □ Stiffness

Breasts-
□ Lumps □ Pain □ Discharge □ Currently Breast-feeding

Respiratory-
□ Cough □ Coughing up blood □ Shortness of breath □ Wheezing □ Painful breathing

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Cardiovascular-
□ Chest pain or discomfort □ Tightness □ Palpitations□ Shortness of breath with activity
□ Difficulty breathing lying down □ Sudden awakening from sleep with shortness of breath

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Gastrointestinal-
□ Swallowing difficulties □ Heartburn □ Change in appetite □ Nausea □ Rectal bleeding
□ Constipation □ Diarrhea □Yellow eyes or skin

Vascular-
□ Calf pain with walking □ Leg cramping

Musculoskeletal-
□ Muscle or joint pain □ Stiffness □ Back pain □ Redness of joints □ Swelling of joints

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Neurologic-
□ Dizziness □ Fainting □ Seizures □ Weakness □ Numbness □ Tingling □ Tremor

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Hematologic-
□ Ease of bruising □ Ease of bleeding

Endocrine-
□ Heat or cold intolerance □ Frequent urination □ Excessive Thirst □ Excessive hunger

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Psychiatric-
□ Nervousness □ Depression □ Memory loss □ Stress □ Other ___________________________

Past Medical History:

Please check if you have EVER had or CURRENTLY have any of the following medical problems:

______ Diabetes	______ Erectile Dysfunction	______ Cushing's Disease
______ Pre-Diabetes	______ High Cholesterol	______ COPD/Emphysema
______ Kidney Disease	______ High Blood Pressure	______ Heartburn/GERD
______ Liver Disease	______ Irregular Periods	______ Fatigue
______ Fatty Liver	______ Bleeding Disorder	______ Depression
______ Stomach Ulcers	______ Gout	______ Thyroid Disease
______ Anemia	______ Heart Valve Disorder	______ Heart Disease
______ Infertility	______ Gallbladder Disorder	______ Anxiety
______ Back Pain	______ Eating Disorder	______ Alcohol Abuse
______ Hip Pain	______ Rheumatic Fever	______ Drug Use
______ Knee Pain	______ Cancer	______ Plantar fasciitis
______ Arthritis	______ Osteoporosis	______ Headaches
______ Heart palpitations	______Shortness of Breath	______ Glaucoma
______ Sleep Apnea	______ Snoring	______ Heart Attack
______ Stroke	______ Fibromyalgia	______ ADD/ADHD
______ Swelling in feet/legs	______ Vitamin D deficiency	______ Chronic Fatigue Syndrome

______ Other____

______ Other____

______ Other____

Gynecologic History:

Pregnancies: Number: ____________________ Dates:___________________________________

Natural Delivery or C-Section (specify): ____

Menstrual Period: How old were you when you started your period?________________________

How long does your period last? _____________________________________

Are your periods regular? YES NO

Do you have pain associated with your period? YES NO

Last menstrual period: ____

Are you currently on Hormone Replacement Therapy? YES NO

Which one? ____

Are you currently using Birth Control? YES NO

Which method? Birth Control Pills IUD Condoms Tubal ligation Vasectomy

Other ____

Surgical History:

Any Surgeries? Yes No

Specify: (List all) and date

____

____

____

____

<u>Family History</u>:

	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: ______________________

<u>Social History:</u>

1) Do you smoke? NO YES If Yes, what do you smoke, how much, and how often?
   ____

2) Do you exercise regularly? NO YES
   If yes, how do you exercise, how often, for how many minutes?
   (For example, walking after dinner, 5 times per week, for 15 minutes each time)
   ____

3) Are you: MARRIED DIVORCED SINGLE

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 and when? __________________________________
7. Previous diets you have followed: Give dates and results of each weight loss effort:
____
____
____
____
____
8. What do you do for a living? ____
9. Describe your work schedule. ____
____
10. Is your spouse, fiancee or partner overweight? Yes No
11. By how much is he or she overweight? ____
12. Are your children overweight? Yes No ____
13. How often do you eat out? ____
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 when you grocery shop? 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?_________________________________

23. Do you drink coffee or tea? Yes No How much daily?__________________________

24. Do you drink regular cola drinks? Yes No How much daily? _________________________

25. Do you drink alcohol? Yes No What kind?_____________________________________

How much daily? _______________Weekly? ___________________Monthly?________________

26. Do you use a sugar substitute? _______________Butter? ____________ Margarine? ____________

27. Do you awaken hungry during the night? Yes No

28. What are your worst food habits? ____
____

29. Snack Habits: Give examples of foods you frequently snack on, and when.
____
____

30. Have you ever been diagnosed or treated by a medical professional for eating disorders such as Anorexia, Bulimia, and Binge Eating Disorder? YES NO If yes, please explain:
____

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

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

33. How many hours do you sleep at bedtime? ____

34. Do you wake up frequently? ____

35. Do you mostly wake up feeling refreshed, or still tired?_____________________________________

36. Do you have morning headaches? YES NO How often? ___________________________

37. Do you snore? _______________ Do you wake yourself up when you snore?___________________

38. Do you fall asleep easily during quiet tasks like reading during the day? ________________________

39. Please describe an average day of eating (This part MUST be filled out!)

Typical Breakfast: What time of day? ______________ Do you usually eat at home / work / restaurant?

____
____
____
____
____

Typical Lunch: What time of day? _______________ Do you usually eat at home / work / restaurant?

____
____
____
____
____

Typical Dinner: What time of day?_________________ Do you usually eat at home / work / restaurant?

____
____
____
____
____

40. Do you feel your energy level is lower than it should be? YES NO

Has this worsened recently?____

41. Do you get out of breath more easily than you used to when you exercise? YES NO

Has this worsened recently?____

42. Please describe your general health goals and improvements you wish to make with your weight loss:

____
____
____

Please Sign and Date this form below

Patient Signature____ Date_________________

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.

This patient history has been reviewed and modified by myself.

Physician Signature ____ *Date* __________

Caren D. Beasley, M.D.