Southern New Hampshire Weight Management

NEW PATIENT MEDICAL HISTORY FORM

Name: (First)________________________________ (Last) ________________________________ (MI)____
Date of Birth: _____/_____/__________
Phone: (Home/Cell)________________________ (Work) ________________________
Primary Care Provider (PCP): ________________________________
Approximate date of last physical exam:________________________

Which of the following would you like to participate in (please choose only ONE; note that you can transfer between programs at any time.)?

__ Surgical program (bariatric surgery) __ Non-surgical program (medical weight loss)
__ Unsure

Have you had bariatric surgery? If so, which one and when?_____________________________________
If you are interested in the non-surgical program, do you think you would ever consider bariatric surgery? Y/N/Maybe ____

How does your weight affect your life and health? ____

Why do you want to lose weight?____
Do you have any specific goals (e.g., weight at which you would feel comfortable, clothing size)?
____

How important is losing weight to you? (please circle one)

not important, somewhat important, moderately important, important, very important

How confident are you that you can make changes? (please circle one)

Not confident, somewhat confident, moderately confident, confident, very confident

What makes it challenging for you to have healthy lifestyle habits? ____________________________

Do you feel you have support trying to lose weight (i.e., family, friends, co-workers, etc.): Yes/No
If no, why not? ____

Weight History

When did you first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____
What is the most you have ever weighed (outside of pregnancy) and when was this? ________________

Life events associated with weight gain (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness
☐ Travel ☐ Injury ☐ Nightshift work ☐ Job change ☐ Quitting smoking
☐ Alcohol ☐ Drugs ☐ Surgery ☐ Menopause
☐ Medication (please list: ____)

Previous weight-loss programs tried (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 ☐ Ketogenic
☐Intermittent Fasting ☐ Meal Replacements (Optifast, HMR, etc…) ☐ Other: ____________________
What was your maximum weight loss? ____
Which, if any, of the above programs were successful? _______________________________________

Have you ever taken any of the following medications? (check all that apply):
☐ Phentermine (Adipex) ☐ Sibutramine (Meridia) ☐ Xenical/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topiramate (Topamax) ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
☐ Naltrexone ☐ Ozempic ☐ Wegovy ☐ **Metformin**
☐ Other (including supplements): ____
What worked? ____
What didn't work and why?____

<u>Nutrition History</u>
Do you or have you ever tracked food intake? Y/N ____
Who does food shopping/preparation at home (circle all that apply)? Self Other _______________
How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____ What beverages do you drink? _________________________
How much water do you drink in a typical day? ____
Do you drink alcohol? Y/N How much? ____________________ Prior treatment for alcoholism? Y / N
List any food intolerances/allergies/sensitivities: ____
Please provide a 24-hour diet history (i.e. list everything you might eat or drink in a typical day):

The quality of your food choices is: ☐ Excellent ☐ Fair ☐ Poor ☐ Could be better
How many times a week do you eat meals not prepared at home? (e.g., from restaurant, cafeteria) _____
Do you feel your food portions are (check one): ☐ Small ☐ Normal ☐ Too large
Do you feel your appetite level is (circle one): ☐ Low ☐ Normal ☐ Excessive or High
After a meal, do you feel full/satisfied? Y/N/sometimes ______________________________________
Do you frequently crave: ☐ Sweet/sugary foods ☐ Salty foods ☐ Other _________________________
Do you do frequently do other things while eating? (i.e. watching TV, Reading, etc…) Y / N___________
Do any of the following cause you to overeat?
☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward ☐ Hunger
☐ Parties ☐ Eating out ☐ Other: ______________________
Is there a particular time of the day you are more likely to overeat? ______________________________
Do you get up in the middle of the night to eat? Y / N If so, how often? _________________________
Do you ever feel out of control while eating? (Y / N)
Have you ever been diagnosed with an eating disorder? (Y / N) If yes, which one? ________________
Have you ever seen a dietitian? Y/N. If yes, when? ____

Exercise: Do you exercise regularly? Y/N
Exercise type: ____
Duration: _____ hours _____ minutes Number of times per week: _____
Do you have any exercise equipment at home? Y/N ___________________________
Does anything limit you from exercising? ___________________________

Stress level (out of 10): ___ Biggest stressors: ___________________________

Sleep:
How many hours do you sleep per night? _____
Do any of the following apply to you: ☐ Sleep study done ☐ Sleep apnea diagnosis ☐ Use CPAP

Medical History
Past medical history (check all that apply):
☐ Heart attack ☐ Angina ☐ Gallbladder removal/stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux ☐ Thyroid problem
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Arthritis ☐ Polycystic Ovarian Syndrome ☐ Bipolar
☐ Glaucoma ☐ Migraines ☐ Seizures ☐Liver disease
☐ Kidney Disease ☐ Kidney Stones ☐ Gestational diabetes ☐ Fatty liver
☐ Blood clots ☐ Frequent use of steroids (e.g., prednisone, Medrol Dosepak)
☐ Cancer (type/s): ____________________ ☐ Other:________________________

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: ____

Do you currently see any of the following providers?
☐ Psychotherapist/psychologist/counselor ☐ Psychiatrist (med prescriber) ☐ Cardiologist
☐ Endocrinologist ☐ Pulmonologist ☐ Nephrologist ☐Gastroenterologist

Social History
Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: ________________
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Occupation:____ (or **retired / disabled**)
Who lives at home with you? ____

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
☐ Alcoholism ☐ Cancer (type/s): ______________________________
Other: ____

Allergies:____

Gynecologic history and symptoms

Age periods started? _____ Age periods ended _____

Periods are/were: Regular (about once a month) / Irregular Heavy / Normal / Light

If still menstruating, last Menstrual Period:_________

Number of pregnancies: _____ Number of children: _____

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

- ☐ Absence of periods
- ☐ Hot flashes
- ☐ Abnormal/excessive menstruation
- ☐ Irregular or missed periods
- ☐ Change in bladder habits
- ☐ Facial hair
- ☐ Receding hair line

General symptoms review

(Check all that apply)

- ☐ Fatigue/tiredness
- ☐ Weakness/low energy
- ☐ Snoring
- ☐ Cough
- ☐ Chest pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Difficulty breathing when flat
- ☐ Swelling ankles/extremities

- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Bloating
- ☐ Indigestion
- ☐ Heartburn
- ☐ Dysphagia/difficulty swallowing
- ☐ Nausea/vomiting
- ☐ Decreased appetite
- ☐ Blood in stools

- ☐ Hair loss
- ☐ Skin rash
- ☐ Acne
- ☐ Purple stretch marks
- ☐ Easy bruising
- ☐ Muscle aches/pain _______________
- ☐ Joint pain ______________________
- ☐ Back pain
- ☐ Dizziness
- ☐ Fainting/Blacking out
- ☐ Headaches
- ☐ Seizures
- ☐ Memory loss
- ☐ Depressed mood
- ☐ Anxiety
- ☐ Loss of interest
- ☐ Insomnia
- ☐ Inability to concentrate
- ☐ Urinary frequency/urgency
- ☐ Nighttime urination

- ☐ Erectile Dysfunction
- ☐ Low libido
- ☐ Heat intolerance
- ☐ Cold intolerance

Additional Comments:

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