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

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

   g. How many hours of sleep do you average per night? _____

   h. Do you take naps often? ❑ Yes ❑ No

CURRENT EXERCISE

3. 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)*

OB/GYN HISTORY

4. Have you had any pregnancies? ❑ Yes ❑ No

a. If yes, how many? _____ Dates: _____

b. Any problems during pregnancy? ❑ Yes ❑ No

If yes, please explain: _____

c. Any difficulty getting pregnant? ❑ Yes ❑ No

d. Any diagnosis of infertility? ❑ Yes ❑ No

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

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

Note: If you have had a hysterectomy, please answer regardless of age

5. **a.** Age of first menstrual cycle: _____

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

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

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

e. When was your last menstrual cycle? _____

f. What is your current form of contraceptive? _____

MEDICAL HISTORY

6. **a.** Past Medical History *(check all that apply)*

❑ Alcohol Abuse	❑ Eating Disorder	❑ Liver Disease
❑ Anemia	❑ Gallbladder Disorder	❑ Osteoporosis/penia
❑ Arthritis	❑ Gout	❑ Thyroid Disease
❑ Cancer	❑ Kidney Disease	❑ Other: _____

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

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

d. History of Diabetes? ❑ Yes ❑ No

What type? ❑ Type I ❑ Type II ❑ Gestational

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

f. History of frequent headaches? ❑ Yes ❑ No

History of migraines? ❑ Yes ❑ No

g. Any known allergies to medications? ❑ Yes ❑ No

If yes, please explain: _____

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

i. Prescription Drugs: *(list all)*

Drug: _____ Dose: _____

Drug: _____ Dose: _____

Drug: _____ Dose: _____

Drug: _____ Dose: _____

Drug: _____ Dose: _____

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

Product: _____ Dose: _____

Product: _____ Dose: _____

Product: _____ Dose: _____

Product: _____ Dose: _____

Product: _____ Dose: _____

Product: _____ Dose: _____

Product: _____ Dose: _____

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

l. History of diarrhea? ❑ Yes ❑ No

m. History of Glaucoma? ❑ Yes ❑ No

n. 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.

SURGICAL HISTORY

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

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

Type: _____ Date: _____

FAMILY HISTORY

8. a. Has any blood relative ever had any of the following?:

If yes, who? (clarify paternal/maternal)

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

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

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

NUTRITIONAL EVALUATION

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

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

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

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

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

_____

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

_____

g. Previous medications (for weight loss) you have tried: _____

_____

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

i. What types of food do you crave, if any? _____

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

k. Do you drink soda? ❑ Yes ❑ No

If yes: Regular? Diet? Zero Sugar? _____

How often? _____

l. Do you drink alcohol? ❑ Yes ❑ No

m. Do you have a history of an eating disorder? ❑ Yes ❑ No

If yes, diagnosis? _____

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

- ❑ Binge Eating
- ❑ Boredom Eating
- ❑ Eating Disorder
- ❑ Emotional Eating
- ❑ Skipping meals on a regular basis
- ❑ Stress Eating
- ❑ Other: _____

FUTURE GOALS

11. a. How ready are you to change? *(0: no way, 10: let's do it yesterday)*

1 2 3 4 5 6 7 8 9 10

b. How willing are you to change?

1 2 3 4 5 6 7 8 9 10

c. How able are you to change?

1 2 3 4 5 6 7 8 9 10

SCREENING QUESTIONS:

12. 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

c. Please use this space to specify anything else you think we need to know about your current health:

_____

_____

_____

_____

_____

_____

_____