Foundation
southern new hampshire health
Weight Management Program
WE ARE SOLUTIONHEALTH

NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Primary Care Provider (PCP): _____
Approximate date of last physical exam:_____

How does your weight affect your life and health? _____
_____
_____

Why do you want to lose weight?_____

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

Weight History

When did you first notice that you were gaining weight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? _____
How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

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			

☐ Medication (please list: _____)

Previous weight-loss programs (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
☐Other: _____
What was your maximum weight loss? _____
Which of the above programs were successful ? _____
Which of the above programs were ***not*** successful?_____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Sibutramine (Meridia) ☐ Xenical/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topiramate (Topamax) ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
☐ Naltrexone ☐ Meal Replacements (Optifast, HMR, etc…)

Other (including supplements): _____
What worked? _____
What didn't work? _____
Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____ What beverages do you drink? _____
Do you get up in the middle of the night to eat? Y / N If so, how often? _____
List any food intolerances/allergies/sensitivities: _____

Please provide a 24 hour diet history (ie list everything you might eat or drink in a typical day):

How often do you eat meals away from your home? (ex. Restaurant meals, take out meals, work cafeteria etc…)_____

Do you have a particular type of cuisine you prefer? (Y / N) _____

Do you have any food / beverage restrictions due to a medical condition ? (Y / N)_____

How much water do you drink in a typical day? _____

Do you do frequently do other things while eating? (ie watching TV, Reading, etc…) (Y / N)_____

Does any of the following cause you to overeat?

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward ☐ Hunger
☐ Parties ☐ Eating out ☐ Other: _____

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food
☐ High fat ☐ Large portions

Favorite foods: _____

Is there a particular time of the day you are more likely to overeat? _____

Do you ever feel out of control when eating? (Y / N) _____

Are you ever worried that you will not have enough food (Y / N)_____

Medical History

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gallbladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux	☐ Thyroid
☐ 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		

☐ Cancer (type/s): _____

☐ Other:_____

Have you ever been diagnosed with an eating disorder? (Y / N) If yes, which one? _____

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass

☐ Hysterectomy ☐ Other: _____

Allergies:_____

Social History

Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)

Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)

Prior treatment for alcoholism? Y / N

Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____

Marijuana: ☐ Never ☐ Current user (_____ times/day)

Occupation:_____ (or retired / disabled)

Exercise type: _____

Duration: _____ hours _____ minutes Number of times per week: _____

Does anything limit you from exercising? _____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Do you feel you have support trying to lose weight? (ie from spouse, family, friends, co-workers, etc…)
Y/N

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

☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____
Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Last Menstrual Period:_____
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)
☐ Recent weight ***loss*** more than 10 pounds
☐ Recent weight ***gain*** more than 10 pounds

☐ Acne	☐ Skin rash	☐ Cough
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Blood in stools	☐ Back pain
☐ Joint pain	☐ Muscle aches/pain	☐ Dizziness
☐ Headaches	☐ Seizures	☐ Weakness/low energy
☐ Anxiety	☐ Depressi	☐ Insomnia
☐ Memory loss	☐ Inability to concentra	☐ Mood changes
☐ Nervousness	☐ Loss of interest	☐ Cold intolerance
☐ Excessive sweating	☐ Hair changes	☐ Heat intolerance
☐ Blood clots	☐ Fatigue/tiredness	☐ Erectile Dysfunction

(Women only)

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

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

Additional Comments: