WEIGHT MANAGEMENT MEDICAL HISTORY FORM

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ❑ Male ❑ Female

Driver's License #: _____ State Issued: _____ Exp: _____

Occupation: _____ Marital Status: _____

Emergency Contact

Name _____

Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Care and Specialty Doctors:

Doctor's Name: _____ Phone: _____

Location: _____

Doctor's Name: _____ Phone: _____

Location: _____

Doctor's Name: _____ Phone: _____

Location: _____

_____

Signature *Date*

QUESTIONS

What is your purpose for having treatment to manage your weight?

What is the reason you want to lose weight?

How long has your weight been a problem?

Are you currently at your heaviest weight? ❑ Yes ❑ No (If no, how much did you weigh at your heaviest weight?)

My worst food habit is...

What methods have you previously tried to lose weight?

Are you a stress eater? ❑ Yes ❑ No Do you eat in the middle of the night? ❑ Yes ❑ No

Does your significant other struggle with weight issues? ❑ Yes ❑ No

Are you scared of needles/needle phobic/faint easily when you have blood taken? ❑ Yes ❑ No

WOMEN ONLY:

Check those questions to which you answer yes (leave the others blank).

❑ Are you trying to achieve pregnancy or planning pregnancy in the near future?

❑ Are you or could you be pregnant?

❑ Are you breastfeeding?

❑ Are you on any type of hormone replacement therapy?

❑ Are you using any type of contraceptives (birth control)?

Number of live births? _____

Signature *Date*

Medications: Please list all prescription medications you currently take, including samples.

Medication Name	Dose	Number of times per day	Doctor

Herbal/Supplements: Please list all vitamins, herbs, enzymes, protein supplements, pro-hormones or any other supplements.

Date of last complete physical exam:_____ ❑ Normal ❑ Abnormal ❑ Never ❑ Can't Remember

List any other medical or diagnostic test you have had in the past two years:

List hospitalizations, including dates and reasons for hospitalization (including surgeries):

Allergies: Pleae list medications, food, or environmental allergies and what reactions have occurred (if any):

_____

_____

_____

_____

Past Medical History and Current Medical Conditions: Please check all that apply to you.

- ❑ Heart Disease (heart attack, rheumatic fever, irregular heartbeat, angina, heart murmur, chest pain)
- ❑ Diseases of the arteries
- ❑ High blood cholesterol
- ❑ Anemia or other blood disorders (i.e. Sickle cell disease, Thalassemia)
- ❑ History of dizziness, seizures, or stroke
- ❑ Medullary thyroid cancer
- ❑ Thyroid disease/problems
- ❑ Parathyroid problems/Adrenal gland problems
- ❑ Diabetes or abnormal blood-sugar tests
- ❑ Phlebitis (inflammation of a vein)
- ❑ Deep vein thrombosis/blood clot in the leg (DVT) or PE (pulmonary embolism)
- ❑ Gallstones or any gallbladder disease (including jaundice)
- ❑ High blood pressure (Hypertension)
- ❑ Severe reflux
- ❑ Breathing problems (such as asthma, COPD, bronchitis)
- ❑ Infective endocarditis
- ❑ Kidney problems including Chronic Kidney Disease (CKD)
- ❑ Pancreas/digestion problems (including acute or chronic pancreatitis)
- ❑ Stomach/duodenumigastric ulcer
- ❑ Liver problems (including hepatitis, liver failure, fatty liver, alcoholic liver disease)
- ❑ Neurological problems (including Parkinson's Disease)
- ❑ Severe stomach/gut problems (incl. inflammatory bowel disease: Crohn's disease or Ulcerative colitis)
- ❑ Irritable bowel syndrome (IBS)
- ❑ Jaundice or gall bladder problems
- ❑ Skin conditions
- ❑ Eating disorder (such as anorexia or bulimia)
- ❑ Mental health problems (including personality disorder, psychosis. diagnosis of depression)
- ❑ Self-diagnosis of depression, low mood, nervous or emotional problems
- ❑ Substance abuse (including alcohol or drugs)

Are you on any blood thinners? ❑ Yes ❑ No Weekly alcohol intake? _____

Do you or have you ever smoked? ❑ Yes ❑ No

At this time, my current exercise routine includes...

_____

_____

Do any of the discussed contraindications apply to you? *Please check all that apply to you.*
Have you or your blood relatives had any of the following (include grandparents, aunts and uncles, but exclude cousins, relatives by marriage and half-relatives)? Check those questions to which you answer yes (leave the others blank).

- ❑ Heart attacks under age 50
- ❑ Strokes under age 50
- ❑ High blood pressure
- ❑ Elevated cholesterol
- ❑ Diabetes
- ❑ Asthma or hay fever
- ❑ Skin allergies
- ❑ Congenital heart disease (existing at birth but not hereditary)
- ❑ Heart operations
- ❑ Red blood cell disorders i.e. Sickle Cell, Thalassemia, and Anemia
- ❑ Glaucoma
- ❑ Kidney Disease
- ❑ Obesity (20 or more pounds overweight)
- ❑ Leukemia or cancer under age 60

Comments:

_____

_____

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_____

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_____

_____

Signature *Date*

We take your symptoms and an evaluation of your entire endocrine system to determine how to treat you, as an individual. Please take the time to fill out the following forms and questionnaires before your visit, and bring them completed along with your insurance card. The questionnaires, although lengthy, help us identify the cause of your problems so that we can get you feeling better quicker.

6811 N. Knoxville Ave., Ste. A | Peoria, IL 61614 309.439.9400
2309 E. Empire St., Ste. 200 | Bloomington, IL 61704 309.740.7970

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