

Peoria 309.439.9400

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:		
<u>c:</u>	D /	

Signature

Date



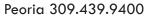
Peoria 309.439.9400

	QUESTIONS
Wh	at is your purpose for having treatment to manage your weight?
Wh	at is the reason you want to lose weight?
Hov	v 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?)
Му	worst food habit is
Wh	at 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
Doe	es your significant other struggle with weight issues? 🗖 Yes 📮 No
Are	you scared of needles/needle phobic/faint easily when you have blood taken? \square Yes \square No
	WOMEN ONLY:
Che	eck 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)?
Nur	nber of live births?



Signature

Date

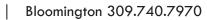




Medications: Please lis	all prescription med	ications you currently take, incl	uding samples.
Medication Name	<u>Dose</u>	Number of times per da	y <u>Doctor</u>
Herbal/Supplements:	Please list all vitamin or any other supplem	s, herbs, enzymes, protein supp	olements, pro-hormones
	or any onler supplen	161113.	
Date of last complete ph	ysical exam:	🗆 Normal 🔲 Abnori	mal 🗆 Never 🚨 Can't Remember
	-		
List any other medica	l or diagnostic tes	t you have had in the pa	st two years:
List hospitalizations.	includina dates ar	nd reasons for hospitalize	ation (including surgeries):
	merouming during di		anon (mareamy congenies).







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 (including Parkinson's Disease) Severe stomach/gut 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				
Do you or have you ever smoked? \(\begin{align*}\text{Yes} \text{No}\\ \end{align*}\)				
At this time, my current exercise routine includes				



Do any of the discussed contraindications apply to you? Please check all that apply to you or your blood relatives had any of the following (include grandparents, aunts and cousins, relatives by marriage and half-relatives)? Check those questions to which you answer ers blank).	incles, but exclude
 □ 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:	
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 2309 E. Empire St., Ste. 200 | Bloomington, IL 61704 309.439.9400 309.740.7970

www.LifePlusMD.com