Patient History

Name:_____ Date _____

Please choose one

1. **Switching PCP or 2. Weight Loss Program(Note: not covered by insurance)**

Medical History

Check any condition that you have or have had in the past. Please give details as to when illness occurred.

Obesity_____ Cancer_____ Anemia_____
Heart Problem_____ Asthma_____ AIDS/HIV_____
Stroke_____ Epilepsy_____ Emphysema_____
Diabetes_____ Stomach Ulcers_____ Glaucoma_____
High Blood Pressure_____ Headaches_____ Allergies_____
High Cholesterol_____ Kidney Disease_____ Pneumonia_____
Thyroid Condition_____ Other (explain) _____

Women's Medical History

Date of last period_____
Date of last Pap smear_____
Have you reached menopause? Yes No
Bleeding after menopause? Yes No
Number of pregnancies_____
Number of miscarriages_____

Social History

Do you smoke? Yes No If yes, how long have been a smoker?
_____
If you have quit smoking, how long ago did you quit?_____
Do you drink alcohol? Yes No How often do you drink?
_____
Number of drinks per week?_____
Do you use drugs for recreational purposes? Yes No
Do you exercise regularly? Yes No
What form of exercise do you do?_____
How many hours per week?_____
Marital status Signal Married Divorced Widowed

Medications

Please identify all medications and dosages you are currently taking.

_____
_____
_____
_____
_____

Past Surgical History

Please list

1. _____Year_____
2. _____Year_____
3. _____Year_____
4. _____Year_____
5. _____Year_____

Allergies

Do you suffer from any allergies to medication? Yes No
If yes, what medications are you allergic to?

_____
_____
_____
_____

Family History

Has a blood relative had any of the following conditions?
Cancer Leukemia Heart Disease High Blood Pressure Thyroid Condition Stroke High Cholesterol Diabetes Stomach Ulcers Alcoholism Asthma Epilepsy Other Condition Please Define_____
_____

Vaccinations

Please check the ones you have received

flu pneumonia Others_____