Patient Medical History Form

ReforMedicine SC
Direct Pay Family Practice

Name: _____ Age:_____ Sex: M F

Tell us about yourself:

Marital Status (circle one): married never married divorced widowed other

How many children do you have? _____ What are their ages? _____

Who lives at home with you? _____

In what town/city do you live? _____

What do you do for a living? _____ Employer: _____

What do you do **now** for **exercise** and how often? None _____, _____min, ____days/week
(type of exercise)

How's your stress level? Low Medium High

Describe your tobacco use:

____ Never smoked cigarettes, cigars or a pipe, used smokeless tobacco
____ Quit smoking/chewing _____ years ago and have not smoked/chewed since
____ Smoke a pipe or cigar, or chew tobacco (circle all that apply)
How much of which?_____
____ Smoke ____ pack(s) cigarettes per day
____ Use tobacco on occasion Which and how often?_____

Do you drink alcohol? Yes No
If Yes, What? _____ How much per week? _____

Do you use any **recreational substances** (e.g. Marijuana)? Yes No Which? _____

How many hours per week do you spend watching TV/playing video games/web surfing? _____

Who has been your regular doctor? _____, Town/City_____

Are you in good health at the present time to the best of your knowledge? Yes No
Explain a "no" answer:

Are you under a doctor's care at the present time? Yes No
If yes, for what? Doctor's Name_____

Are you taking any **medications** at the present time? Yes No

Please **list ALL Prescription and Over the Counter medications you take regularly**

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

Are you **allergic** or have **bad reactions** to any medications? Yes No

Please list which:	What happens?	Please list which:	What happens?

Past Medical History: (check all that apply to YOU)

_____ High Blood Pressure	_____ Diabetes	_____ Heart Disease/Attacks
_____ Depression	_____ Measles	_____ Tonsillitis
_____ Anxiety	_____ Mumps	_____ PTSD
_____ Kidney problems	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Cancer
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ ADHD/ADD	_____ Typhoid Fever
_____ Jaundice	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Headaches
_____ Asthma	_____ Allergies	_____ Sleep Apnea
_____ Glaucoma	_____ Swelling/edema	_____ Disabilities
_____ Sexually transmitted infections		_____ Other (please describe):

Have you had any serious injuries (head injuries, car accidents, major falls, major traumas)? Yes No

Specify (List all) Date

Have you EVER had any operations or hospitalizations? Yes No

Specify: (List all) Date

Gynecologic History: (Women and Girls Only)

How many times have you been pregnant?

How old were you when you had your first menstrual period? _____ years old

How long do your periods last? _____day

How often do you get them? Every _____ weeks

Are they regular? Yes No Are they abnormally painful? Yes No

When did your last menstrual period start? _____

Are you currently using: Birth Control Pills: Yes No Type: _____

Hormone Replacement Therapy: Yes No Type: _____

What year was your last pap smear?_____

Have you ever had a pap smear that required treatment? Yes No Year

Family History:

	Age	Health (good/poor)	Disease	Cause of Death
Father:				
Mother:				
Brothers:				
Sisters:				

Have any of your **parents, brothers, sisters, or children** ever had any of the following:

Asthma	Yes No	Who:	
High Blood Pressure	Yes No	Who:	
Kidney Disease	Yes No	Who:	
Diabetes	Yes No	Who:	
Psychiatric Disorder	Yes No	Who:	
Heart Disease/Stroke	Yes No	Who:	
Colon Cancer	Yes No	Who:	
Breast Cancer	Yes No	Who:	
Ovarian Cancer	Yes No	Who:	
Prostate Cancer	Yes No	Who:	
Other condition(s) that run(s) in family?			

Review of Body Systems

Circle any of the following symptoms that you are experiencing AT THIS TIME:

Unexpected weight loss/gain	Shortness of breath	Change in bowel patterns	Blood in urine	Sadness or depression	Women Only
Swollen glands	Chest pain	Heartburn	Pain urinating	Anxious or nervous	Vaginal discharges
Trouble sleeping	Cough	Abdominal pain	Urinating too frequently	Drink too much	Pelvic pain
Feeling sick	Blood in sputum	Trouble/pain swallowing	Incontinence	Skin rashes	Breast lumps
Longstanding pain	Wheezing	Nausea or vomiting	Abnormal urge to urinate	Unexplained hair loss	Nipple discharge
Fever/chills /sweats	Snoring	Vomiting blood	Joint swelling	Changing moles/lesions	Men Only
Double vision	Stop breathing in sleep	Yellow skin	Abnormal bleeding/bruising	Skin growths	Erection issues
Loss of vision	Not well rested after full night sleep	Black/tar in stools	Unexplained lumps or masses		
Eye pain	Swelling in legs/ankles	Blood in stools	Body part that does not work		
Loss of hearing	Ulcers/Wounds on feet	Constipation	New/unusual headache		
Change in voice	Rapid/pounding heartbeats	Diarrhea	Falling down		
Faint/pass out	Calf/leg pain with walking	Trouble emptying bladder			

Health Goals:
Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form. Please remember to bring it with you to your next appointment.

NON-MEDICAL WEIGHT LOSS PATIENTS—STOP HERE 

Medical Weight Loss Patients Only –PLEASE CONTINUE

Your Starting Point

Weight History:

Weight at 20 years of age: _____ lbs. Weight one year ago: _____ lbs. Present Weight: _____ lbs.
1.
How much would you LIKE to weigh **long term (your goal weight)**? _____ Lbs.

In what **time frame** would you like to be at your desired weight? _____

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

When and why did you begin gaining excess weight? (Give reasons, if known): _____

_____

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

How did you decide to come to ReforMedicine to help you with your weight?

_____

_____

What are the **most important reasons** for your decision to lose weight? (list as many as you can think of, use back of page if needed)

Your Starting Point (continued)

Have you ever taken a medication(s) that **caused you to gain** weight? Yes No
If yes, please list:
_____

Do you have a **significant other who is overweight**? Yes No If yes, by how much? _____lbs.

How often do you **eat out**? _____ times per week

Food allergies/intolerances: _____ Food **dislikes**:_____

Food(s) you **crave**: _____

Are there any specific **times that you crave food**? If so when? _____

What **sugared beverages** do you drink routinely:
Juice Regular soda Sweetened Tea Sports drinks Coffees Other

Do you awaken **hungry during the night**? Yes No
What do you do? _____

What are your **worst food habits**? _____

Snack Habits: What? _____ How much? _____ When? _____

When you are under a **stressful situation** at home or work, do you tend to **eat more**? Yes No
If yes, explain: _____

Are you **currently** undergoing a **stressful situation** or an emotional upset? Yes No
Explain:_____

Briefly tell us about your **usual eating patterns**:

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
Where: _____	Where: _____	Where: _____

What **weight loss programs** have you done before? Give approximate dates and results

Have you ever used medications for **weight loss**? If so, which?_____

Are you currently using any meal replacements, shakes, bars, etc.? Please describe._____
_____