ReforMedicine SC
Medical Weight Loss Specialists

Name:_____ Date of Birth: _____/_____/_____

Describing My Current Climate

I am…	Married	Never Married	Divorced	Widow/ Widower	Other:	
# of Children…	0	1	2	3	4	Other: ____
I live at home with…	Name: Age:	Name: Age:	Name: Age:	Name: Age:	Name(s): Age(s):	
The town/city I live in is…						
For a living I... (occupation)						
At this time, my exercise routine includes…	Activity:	Minutes:	Times/ week:			
My Current Stress level is…	None	Low	Medium	High		
My biggest stressor is…	Job	Relationship	Health	Other:		
My tobacco use is…	Current	Former	Never	Quitting		
My current alcohol use is...	None	Occasional	Weekly	Daily	A Problem	
My current recreational substance use is…	None	Type:	Frequency:			
My current TV/computer time per week is…	Less than 7hrs	7 to 15 hrs.	Over 15 hrs.			
I have had a problem with drug or alcohol addiction in past…	No	Yes	Which?			

My **Most Important Reasons** for wanting to *Change My Health Climate* are:

I decided to come to ReforMedicine Medical Weight Loss to help me with my weight because:
_____

My weight at age 20 was _____ lb.
My Weight one year ago was:_____ lb.
The MOST I ever weighed (non-pregnant) was_____ lb.
I began to gain weight because: _____
My **worst** food habit is_____

I am a **stress** eater	Yes	No	
I eat in the middle of the night	Yes	No	
My significant other has a weight issue	Yes	No	N/A

During the last 3 months, I have had episodes of excessive overeating where I ate more than what most people would eat in a similar period of time: Yes No

- *If "No" go to **Beverage** box below*
- *If "Yes" complete the following:*

During these episodes I feel I have NO CONTROL over my eating Yes No
I eat during these episodes even when I am not hungry Yes No
During these episodes I feel embarrassed by how much I ate Yes No
During these episodes I feel disgusted with myself, or guilty afterward Yes No
In the past 3 months, I have sometimes made myself vomit to try to control my weight Yes No

BEVERAGE: I **drink** the following routinely (circle all that apply):

Beverage	Number per Week
Fruit Juice	
Sweetened Tea	
Sports Drinks	
Energy Drinks	
Regular Soda	
Diet Soda	

Typical Meals for me include: (if "none", please note that)

Breakfast	Lunch	Supper	Snacks

I have done the following **weight loss programs** before:

Program	Year	Result

I have used weight loss medication before: No Yes If yes, which? _____

I am currently using weight loss products: No Yes If yes, which? _____

The person(s) closest to me support my intentions to do this program: No Yes Unsure

Long term, I would like to maintain my weight at _____lbs. (This is my "New Climate" weight)

I would like to be at my "New Climate" weight in _____ months

If you would like to be added to our private ReforMedicine Medical Weight Loss Facebook site for additional recipes and support, please provide the e-mail address that is associated with your Facebook account:

_____

My Past Health History

My regular doctor is: _____ Town: _____

Communication in healthcare is important in order for you to receive the most comprehensive care possible.
Would you like us to communicate with your regular doctor about your care here at ReforMedicine? Y / N

At this time my overall health is (circle): Excellent Good Fair Poor

Previous or Current Health **Conditions I have had** include: (check all that apply to you)

	High Blood Pressure		Depression		Sleep Apnea		Thyroid Problems
	Diabetes		Anxiety		Asthma		Gout
	Heart Disease		PTSD		COPD		Arthritis
	Kidney Disease		Binge Eating Disorder		Acid Reflux		Fibromyalgia
	Chronic Leg Swelling		Anorexia Nervosa		Irritable Bowel/Colitis		Osteoporosis
	Bleeding Disorder		Bulimia		Fatty Liver		Urinary Incontinence
	Blood Clot		ADHD/ADD		Crohn's Disease		Polycystic Ovaries
	Anemia		Bipolar Illness		Ulcerative Colitis		Menopause
	Cancer		Alcohol/Drug abuse		Liver/Gallbladder disease		Other
	Eczema		Headache/Migraine		Stomach Ulcers		

Surgeries I have EVER had include:

Type	**Date**	**Type**	**Date**
1.		**4.**	
2.		**5.**	
3.		**6.**	

Hospitalizations, and/or Serious Injuries I have EVER had include:

Reason	Hospital Name	Date
1.		
2.		
3.		

I am **allergic** to, or do not tolerate the following medicines:

None (circle if appropriate)	**2.**
1.	**3.**

***Prescription* Medications** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

***Over The Counter* Medications and/or Supplements/Vitamins** I CURRENTLY take are:

Medication Name	Dose and Frequency	Medication Name	Dose and Frequency

My **Family's Health** History (circle brother or sister as appropriate; check all that apply)

Disease	**Father** Age: Living: Y N	**Mother** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N	**Brother/Sister** Age: Living: Y N
Heart Attack/Stroke						
Diabetes						
Cancer						
Psychiatric						
Obesity						
Other						

Symptoms I am **experiencing at this time**: (check all that apply)

	Unexpected Weight Loss/Gain		Ulcers/Wounds on feet		Sadness/Depression
	Swollen Glands		Calf or leg pain while walking		Anxiety/Nervousness
	Feeling Sick		Change in bowel habits		New/unusual headaches
	Longstanding pain		Heartburn		Falling down
	Fever/Chills/Sweats		Abdominal Pain		Skin rashes
	Disturbance in Vision		Painful or trouble swallowing		Unexplained hair loss
	Eye Pain		Nausea or vomiting		Changing moles
	Hearing Loss		Yellow skin/eyes		Drinking too much
	Voice Change		Black tar/blood in stools		Low sex drive
	Fainting Spells		Constipation		Women Only
	Rapid/pounding heart		Diarrhea		Vaginal discharge
	Shortness of breath		Trouble Emptying Bladder		Pelvic Pain
	Chest Pain		Blood in urine		Breast Lumps
	Cough		Painful urination		Nipple discharge
	Blood in Sputum		Urinating too frequently		Men Only
	Wheezing		Urinary incontinence		Erectile dysfunction
	Loud Snoring		Abnormal urge to urinate		
	Stop Breathing in Sleep		Joint Swelling		
	Not well rested after full night sleep		Abnormal Bleeding/Bruising		
	Swelling in legs/ankles		Unexplained lumps or masses		