



COMPREHENSIVE OBESITY MANAGEMENT PROGRAM

PATIENT HISTORY FORM

Patient Name: \_\_\_\_\_  Male  Female
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status:  S  M  W  D  SEP
Occupation: \_\_\_\_\_
Spouse/Significant Other's Name \_\_\_\_\_ Phone # \_\_\_\_\_
Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Table with 2 columns: Height, Weight

Goal Weight: \_\_\_\_\_ Age when you were last at goal weight: \_\_\_\_\_

Do you have any spiritual practices, of which you would like to make us aware, that would impact the medical care plan we would provide for you?  Yes  No

Your Family History: Please check which of the following conditions that your blood-related family members have experienced. Please indicate by circling which family member was affected.

Table with 4 columns: Condition, Mother, Father, Other

Your Medical History:

When was your last physical exam with your primary care physician? \_\_\_\_\_



**Sleep History:**

Briefly describe your sleep pattern\_\_\_\_\_

Have you had a sleep study? \_\_\_Yes \_\_\_No If yes, please provide date\_\_\_\_\_

Please mark all that apply:

**Respiratory:**

- \_\_\_\_\_ Sleep Apnea
- \_\_\_\_\_ Snore
- \_\_\_\_\_ Headaches
- \_\_\_\_\_ Feel exhausted after 8 hours of sleep
- \_\_\_\_\_ Hold breath or stop breathing when sleeping
- \_\_\_\_\_ Environmental/Seasonal Allergies
- \_\_\_\_\_ Shortness of Breath: \_\_\_\_\_ On stairs/ hills  
\_\_\_\_\_ At Rest, \_\_\_\_\_ Walking
- \_\_\_\_\_ COPD
- \_\_\_\_\_ Asthma
- \_\_\_\_\_ Emphysema
- \_\_\_\_\_ TB
- \_\_\_\_\_ Blood clot in lungs
- \_\_\_\_\_ Bronchitis

Do you use a BIPAP or CPAP? \_\_\_\_\_ yes, \_\_\_\_\_ no

\_\_\_\_\_ Wake up gasping for breath \_\_\_\_\_ Fall asleep while reading or driving

**Musculoskeletal:**

- \_\_\_\_\_ Arthritis
- \_\_\_\_\_ Knee Pain
- \_\_\_\_\_ Chronic Fatigue
- \_\_\_\_\_ Other\_\_\_\_\_
- \_\_\_\_\_ Back Pain
- \_\_\_\_\_ Gout
- \_\_\_\_\_ Fractured hip, wrist or spine (circle)
- \_\_\_\_\_ Spinal Disc problems
- \_\_\_\_\_ Fibromyalgia

**Nervous System:**

- \_\_\_\_\_ Neuropathy
- \_\_\_\_\_ Dizziness
- \_\_\_\_\_ Other Neurological Disorders\_\_\_\_\_
- \_\_\_\_\_ Serous Problems with memory or difficulty thinking
- \_\_\_\_\_ Parkinson's disease
- \_\_\_\_\_ Headache/Migranes
- \_\_\_\_\_ Epilepsy/seizures
- \_\_\_\_\_ Stroke (CVA)

**Gastrointestinal:**

- \_\_\_\_\_ Ulcers
- \_\_\_\_\_ Crohn's Disease
- \_\_\_\_\_ Colon Polyps
- \_\_\_\_\_ Liver Disease
- \_\_\_\_\_ Change in Bowels
- \_\_\_\_\_ Reflux/GERD
- \_\_\_\_\_ Ulcerative Colitis
- \_\_\_\_\_ Diverticulosis
- \_\_\_\_\_ Gallbladder Disease
- \_\_\_\_\_ Other\_\_\_\_\_
- \_\_\_\_\_ Hernia
- \_\_\_\_\_ Hemorrhoids
- \_\_\_\_\_ Hepatitis
- \_\_\_\_\_ Dental Problems

**Cardiac:**

- \_\_\_\_\_ Angina/Chest Pain
- \_\_\_\_\_ Heart Murmur
- \_\_\_\_\_ High Cholesterol
- \_\_\_\_\_ Congestive Heart Failure
- \_\_\_\_\_ Irregular or Rapid Heart Beat
- \_\_\_\_\_ High Blood Pressure
- \_\_\_\_\_ Heart Attack (\_\_\_\_\_year)

**Endocrine:**

- \_\_\_\_\_ Diabetes
- \_\_\_\_\_ Hypothyroidism
- \_\_\_\_\_ Visual Changes
- \_\_\_\_\_ Abnormal hair growth
- \_\_\_\_\_ Other\_\_\_\_\_
- \_\_\_\_\_ Infertility
- \_\_\_\_\_ Hyperthyroidism
- \_\_\_\_\_ Voice Changes
- \_\_\_\_\_ Increase in thirst or urination
- \_\_\_\_\_ Irregular periods
- \_\_\_\_\_ Excessive hot/cold

**Ear and Nose:**

\_\_\_\_ Cataracts                      \_\_\_\_ Macular degeneration                      \_\_\_\_ Glaucoma  
\_\_\_\_ Sinus Infections                      \_\_\_\_ Hearing loss/hearing aid                      \_\_\_\_ Wear glasses  
\_\_\_\_ Wear contacts                      \_\_\_\_ Hay Fever

**Blood Disorders:**

\_\_\_\_ Anemia                      \_\_\_\_ Bleeding or clotting problems  
\_\_\_\_ Iron Deficiency                      \_\_\_\_ Other \_\_\_\_\_

**Vascular:**

\_\_\_\_ Leg Ulcers                      \_\_\_\_ Edema (Swelling of Legs)  
\_\_\_\_ Peripheral Vascular Disease

**Genitourinary:**

\_\_\_\_ Kidney disease                      \_\_\_\_ Prostate disease                      \_\_\_\_ Difficulty urinating  
\_\_\_\_ Kidney Transplant \_\_\_\_ year  
\_\_\_\_ Frequent bladder or kidney infections  
\_\_\_\_ Other \_\_\_\_\_

**OB / GYN:**

\_\_\_\_ Number of pregnancies                      \_\_\_\_ Number of Children  
Date of onset of menses \_\_\_\_\_  
Date of onset of menopause (if applicable) \_\_\_\_\_

**Cancer:**

Cancer Type: \_\_\_\_\_ Year: \_\_\_\_\_  
Treatment: \_\_\_\_\_

**Social History:**

Smoker: \_\_\_\_ Yes, \_\_\_\_ No  
\_\_\_\_ Cigarettes, \_\_\_\_ pipe, \_\_\_\_ cigar, \_\_\_\_ packs per day x \_\_\_\_ years

**Alcohol:**

Social drinker, habitual drinker \_\_\_\_ # of drinks per day/week.

**Other substance:**

Type & Use \_\_\_\_\_

**Surgical History:** Please list any illnesses or operations that required hospitalization:

Year	Illness/Operation	Year	Illness/Operation

Have you undergone any previous gastric surgery, stomach stapling? \_\_\_\_ Yes, \_\_\_\_ No

Do you have any other health concerns? \_\_\_\_\_  
\_\_\_\_\_



**Prescription Diet Medications:** (Please check the medications you have taken)

Medication	Starting Date: (Month/Year)	Ending Date: (Month/Year)	Pounds Lost
<input type="checkbox"/> Fen-Phen			
<input type="checkbox"/> Phenteramine (Fastin, Adipex)			
<input type="checkbox"/> Meridia (sibutramine)			
<input type="checkbox"/> Xenical (orlistat)			
<input type="checkbox"/> Other:			

**Eating Behaviors:**

Are you currently following a diet? Yes No If yes, which diet: \_\_\_\_\_

Are you currently taking vitamins? Yes No If yes, please list them: \_\_\_\_\_

Do you have any food allergies/intolerances? Yes No

If yes, please list them: \_\_\_\_\_

**Please check the following behaviors that contribute to your weight problems:**

- Skip meals/Inconsistent meal pattern Specify: \_\_\_\_\_
- Frequent Snacking-day, night or both Specify: \_\_\_\_\_
- Portion Control Specify: \_\_\_\_\_
- Eating too fast Specify: \_\_\_\_\_
- Sweets (sugar, candy, cookies, ice cream) Specify: \_\_\_\_\_
- Starches (breads, pastas, potatoes) Specify: \_\_\_\_\_
- Fats (fried foods, butter, margarine) Specify: \_\_\_\_\_
- Fast Food Specify: \_\_\_\_\_

- Emotional Eating- stress, boredom, depression, anger **(circle one)**
- Binge eating (eating unusually large amounts of food with lack of self control)  
If checked off, when was your last binge and what food did you binge on?  
\_\_\_\_\_

- Purging/Vomiting/Laxatives to lose weight  
If checked off, please describe when, how long, and were you professionally treated?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please answer the following:**

How many meals per day do you eat? \_\_\_ How many snacks do you eat per day? \_\_\_

Who cooks your meals? \_\_\_\_\_

Do you eat breakfast regularly? Yes No

List the beverages you drink mostly? \_\_\_\_\_

Do you drink water? Yes No If yes, how much per day? \_\_\_\_\_

What are your worst food habits? \_\_\_\_\_

Which food do you crave the most? \_\_\_\_\_

How often do you eat at fast food restaurants? \_\_\_\_\_

If you eat fast food, which restaurants do you frequent? \_\_\_\_\_

**Typical Eating Pattern:**

<b>Breakfast</b>	
<b>Lunch</b>	
<b>Dinner</b>	
<b>Snacks</b>	

**Physical Activity Assessment:**

How did you get here today?  Drove myself  family member drove me  
 Public transportation  Other \_\_\_\_\_

Are you currently exercising?  Yes,  No If yes, what type and how often?  
 \_\_\_\_\_

Have you used an exercise program or physical activity in the past as part of a weight loss program?  Yes  No

If yes, what type of activity did you perform & how often? \_\_\_\_\_

Type of Activity	Frequency (how long & how often? Example: 20 mins., once per week, 1 hr. per month, 5 minutes daily, etc.)
<input type="checkbox"/> Swimming	_____
<input type="checkbox"/> Walking	_____
<input type="checkbox"/> Gardening	_____
<input type="checkbox"/> Exercise class (kind of class)	_____
<input type="checkbox"/> Yoga	_____
<input type="checkbox"/> Tai Chi	_____
<input type="checkbox"/> Bicycle	_____
<input type="checkbox"/> Weight Lifting	_____
<input type="checkbox"/> Other _____	_____

Please list any activities you enjoyed as a child. \_\_\_\_\_

Please check the box that best describes the role you believe physical activity will have as a realistic part of your weight loss program?

Extremely important  Somewhat important  Not important

Please describe your current living situation; do you live:  in the city  
 outside the city.

Do you have someone who will exercise with you?  Yes  No

Please rate these daily activities as follows: 1= Challenging 2= Somewhat challenging 3=Not challenging/Easy

Getting out of bed in the morning \_\_\_\_\_  
Brushing your teeth \_\_\_\_\_  
Getting dressed \_\_\_\_\_  
Going up/down stairs \_\_\_\_\_  
Performing household chores \_\_\_\_\_  
Driving \_\_\_\_\_  
Performing errands/shopping \_\_\_\_\_  
Walking short distance \_\_\_\_\_  
Walking to the bathroom \_\_\_\_\_

If you have ever received any kind of Physical or Occupational therapy please list the condition and date of treatment below:

Condition \_\_\_\_\_ Dates \_\_\_\_\_  
Condition \_\_\_\_\_ Dates \_\_\_\_\_

**Psychosocial History:**

Have you ever participated in counseling or psychotherapy? \_\_\_Yes \_\_\_No

Have you ever been treated for depression/anxiety disorder? \_\_\_Yes \_\_\_No

If yes, where, when and duration of treatment: \_\_\_\_\_

\_\_\_\_\_

Do you have a family history of mental illness or addiction (for example, alcohol or drug?) \_\_\_Yes \_\_\_No If yes, please list the relation to you & the addiction.

\_\_\_\_\_

Have you ever attempted suicide? \_\_\_Yes \_\_\_No  
If yes please describe when & the circumstances. \_\_\_\_\_

\_\_\_\_\_

Have you ever been a victim of abuse (physical, emotional, or sexual) \_\_\_Yes, \_\_\_ No

Are you planning any major life changes in the next year? \_\_\_Yes, \_\_\_No

If so, what? \_\_\_\_\_

What is the most significant source of stress at this time? \_\_\_\_\_

\_\_\_\_\_

What is your method of coping with stress? \_\_\_\_\_

\_\_\_\_\_

Who will make up your support system? What is their relationship to you? \_\_\_\_\_

\_\_\_\_\_



**Provider List:**

It is important that we keep your health care providers informed of your health status. Please complete the following. This is required information!

**Telephone and Fax Numbers**

Primary Care Physician

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Address: \_\_\_\_\_

Pulmonologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Gastroenterologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Orthopedist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Neurologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Cardiologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Psychiatrist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Endocrinologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Gynecologist

\_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\_\_\_\_\_ **Date** \_\_\_\_\_

**Reviewed with patient by David G. von Rueden, M.D./ Babak Moeinolmolki, M.D./ Kathi Storm, C.R.N.P.**