PATIENT HISTORY AND PHYSICAL FORM

Name_____
LAST FIRST MIDDLE I

SSN#_____ Date of Birth_____ Age_____

Sex_____ Marital Status_____ Occupation_____

Home Address_____

City_____ State_____ Zip Code_____

Home Phone #(_____)_____Cell Phone # (_____)_____

Work Phone #(_____)_____Email Address_____

Emergency Contact_____ Phone #_____

How were you referred to our office?_____

Height_____ Weight_____ BMI _____

Allergies_____

Social History:

Do you smoke? Yes No How many packs per day? _____ Quit____ yrs ago

Do you drink alcohol? Yes No How frequently? _____

Do you use recreational drugs? Yes No How frequently?_____

Surgical History:

Surgery	Year	Surgeon/City

Medical History:

Diabetes Yes No Year Diagnosed _____ Current A1C_____

Oral Medications Insulin Diet and Exercise Avg Blood Sugar _____

Hypertension Yes No Treated with medications Yes No

Heart Disease Yes No **Angina** Yes No **Stroke** Yes No

Heart Attack Yes No What year _____**Congestive Heart Failure** Yes No

Have you ever undergone any testing on your heart? Yes No When?_____

High Cholesterol or Triglycerides Yes No **Blood Clot** Yes No

Sleep Apnea Yes No Do you use a C-Pap Machine or Oxygen Yes No

Have you ever undergone a Sleep Study? Yes No When?_____

Bone and Joint Pain Yes No Areas affected _____

Currently taking pain medication or anti-inflammatory for condition Yes No

Urinary Incontinence Yes ❒ No ❒ **Reflux or Heartburn** Yes No

Have you ever been diagnosed with a hernia Yes No Type _____

Shortness of Breath Yes No Activity induced Yes No

Other _____

Family History:

Please list all medical problems including obesity
Father _____
Mother _____
Siblings _____

Weight History:

Please completely fill out the enclosed Weight Loss History form. You must include the last five years and list an approximate high weight for each year.

What has been your highest weight ever?_____ When?_____

How long have you been overweight year_____ age_____

Current clothing size: pants _____ shirt _____ dress_____ Goal weight/size_____

Have you previously had surgery in order to lose weight? Yes No

If yes, what procedure?_____

Year_____ Surgeon_____ Hospital_____

Mental History:

Are you currently taking any drugs for depression or anxiety? Yes No

Are you currently being treated by a mental health provider? Yes No

What reason _____

Name of physician or therapist _____

If you are currently seeing a mental health provider a clearance letter from your doctor will be required.

Have you been treated in the past by a mental health provider? Yes No

What reason _____Year_____

By signing the following form I certify that the above stated information is true and complete to my understanding and knowledge.

_____ _____

Signature Date

Name:_____

MEDICATION SHEET

MEDICATION NAME	DOSAGE	FREQUENCY

VITAMINS, OVER THE COUNTER MEDICATIONS, ETC.:

ALLERGIES:

PHARMACY NAME, CITY, NUMBER: