

# 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: