Tel: 302-401-0606 **Fax: 214-433-6327** **www.bwmedmd.com**
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NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight affect your life and health?
_____

Weight History
When did you become overweight?
o Childhood o Teens o Adulthood o Pregnancy o Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
o Stress o Marriage o Divorce o Illness o Medication abuse o Travel o Injury
o Nightshift work o Insomnia o Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
o Weight Watchers o Nutrisystem o Jenny Craig o LA Weight Loss o Atkins
o South Beach o Zone diet o Medifast o Dash diet o Paleo diet

o HCG diet o Mediterranean diet o Ornish diet o Other:

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What was your maximum weight loss?

What are your greatest challenges with dieting?

Have you ever taken medication to lose weight? (check all that apply):
o Phentermine (Adipex) o Meridia o Xenecal/Alli o Phen/Fen
o Phendimetrazine (Bontril) o Topamax o Saxenda o Diethylpropion
o Bupropion (Wellbutrin) o Qsymia o Contrave
Other: _____
What worked?
_____
What didn't work?
_____
Why or why not?
_____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
o Soda o Juice o Sweet tea o Coffee/tea If so, how many times per day? _____
Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____
Eating triggers (check all that apply):
o Stress o Boredom o Anger o Seeking Reward o Parties o Eating Out
o Fast Food o Other: _____

Food cravings:
o Sugar o Chocolate o Starches o Salty o High Fat o Large Portions
Favorite foods:
_____

Medical History

Exercise type:
_____

Duration: _____ hours _____ minutes Number of times per week: _____

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What prevents you from exercising?

_____

How many hours do you sleep per night? _____ How times do you get up during the night? _____

Do you feel rested in the morning? _____

Past medical history (check all that apply):

o Heart attack o Angina o Gall bladder stones o Sleep apnea
o High blood pressure o Stroke o Indigestion/reflux arthritis o Thyroid
o High cholesterol o Diabetes o Celiac disease o Anxiety
o High triglycerides o Gout o Pancreatitis o Depression
o Infertility o Polycystic Ovarian Syndrome
o Cancer (type/s):

_____

Have you ever be diagnosed with an eating disorder? Y / N If yes, which one?

_____

Past surgical history (check all that apply):

o Gastric bypass o Gastric banding o Gastric sleeve o Gall bladder o Heart bypass o Hysterectomy o Other:

_____

Medications (list all current medications and dosages):

_____ _____ _____
_____ _____ _____
_____ _____

Allergies:

(Medications)_____

_____

(Food)_____

_____

Social History

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Smoking: o Never o Current smoker (_____ packs/day) o Past smoker (quit _____ years ago)
Alcohol: o Never o Occasional o Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: o Never o Current o Past o Type of drugs: _____
Marijuana: o Never o Current user (_____ times/day)

Family History

Obesity (check all that apply): o Mother o Father o Sister o Brother o Daughter o Son
Diabetes (check all that apply): o Mother o Father o Sister o Brother o Daughter o Son
Other (check all that apply): o High blood pressure o Heart disease o High cholesterol o High triglycerides o Stroke o Thyroid problems o Anxiety o Depression o Bipolar disorder o Alcoholism o Cancer (type/s): _____ Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____
Periods are: Regular / Irregular Heavy / Normal / Light
Number of pregnancies: _____ Number of children: _____
Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

o Recent weight loss more than 10 pounds		
o Recent weight gain more than 10 pounds		
o Acne	o Skin rash	o Cough
o Snoring	o Shortness of breath	o Chest pain
o Difficulty breathing when flat	o Fainting/Blacking out	o Palpitations
o Swelling ankles/extremities	o Abdominal pain	o Bloating
o Constipation	o Diarrhea	o Food intolerance
o Dysphagia/difficulty swallowing	o Indigestion	o Nausea/vomiting
o Increased appetite	o Decreased appetite	o Heartburn

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o Gas and bloating o Urinary frequency/urgency o Slow urine flow
o Nighttime urination o Loss of urine control o Blood in stools

o Back pain (upper) o Back pain (lower) o Joint pain
o Muscle aches/pain o Dizziness o Headaches
o Seizures o Weakness/low energy o Anxiety
o Depression o Insomnia o Memory loss
o Inability to concentrate o Mood changes o Nervousness
o Loss of interest o Cold intolerance o Excessive sweating
o Hair changes o Heat intolerance o Blood clots
o Fatigue/tiredness

(Men only)
o Difficulty with erections o Loss of interest in sex o Low testosterone

(Women only)
o Absence of periods o Hot flashes o Change in bladder habits
o Abnormal/excessive menstruation o Facial hair o Loss of interest in sex
o Difficulty getting pregnant

Comments:
_____