DEACONESS WEIGHT LOSS SOLUTIONS

MEDICAL HISTORY FORM FOR INITIAL CONSULTATION

Name _____ **Date of Birth** _____ **Age** _____

Primary Physician _____ **Physician's Phone #** _____

Date and reason for most recent office visit _____

MEDICAL CONDITIONS -

PLEASE CHECK ONLY THOSE FOR WHICH YOU ARE BEING TREATED:

Condition	**Year Diagnosed**
____Diabetes	_____
____High Blood Pressure	_____
____High Cholesterol	_____
____Heart Disease	_____
____Heart Attack	_____
____Sleep Apnea	_____
___CPap / BiPap	_____
____Asthma	_____
____Arthritis	_____
____Cancer	_____

(indicate the type and location of cancer)

_____

____Acid Reflux / GERD	_____
____Depression/Anxiety/BiPolar disorder	
____GI procedures	_____
____Back Pain	_____
____Joint Pain	_____
____Other: _____	

Are you allergic to any medications? YES_____ NO_____

MEDICATION ALLERGY:	**REACTION TO MEDICINE:**
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS

(include over-the-counter medicines & vitamins):

Name of Drug	**Dose / Frequency**	**Reason Taken**

On Oxygen? _____

HISTORY OF SURGERIES AND HOSPITALIZATIONS:

DATE	TYPE OF SURGERY OR HOSPITALIZATION	REASON

**If you have been hospitalized in the last 6 months, please explain why: _____

_____

SOCIAL HISTORY

Do you smoke? YES___ NO___ If YES, how many packs per day? _____ For how long?_____

How old were you when you started smoking? _____ Are you willing to quit? _____(yes/no)

If NO, but you have smoked in the past, what year did you **stop** smoking? _____ Age started?_____

Do you use E-cigarettes/vapor? _____(Yes/No) Do you use nicotine in the form of patches, losenges, or gum? _____(Yes/No)

Do you drink alcohol? Daily___ Weekly___ Rarely___ Never___ IF DAILY, how many drinks per day? _____

Did you drink heavily in the past? _____(Yes/No) If yes, are you still? _____(Yes/No) OR, When did you stop? _____

Are you currently using Illegal drugs? YES____ NO____ Have you used illegal drugs in the past? YES___ NO____

*If YES, what drug(s), substances? _____

**How much did you use, when did you start and when did you stop the above substances? _____

_____

FAMILY HISTORY

Please fill out the attached Family History form as completely as possible. This information is very important.

Please include any other important health information that is not covered elsewhere on this Medical History form:

_____

YOUR SIGNATURE _____ **DATE**_____

FAMILY HISTORY

PLEASE CHECK (✓) ALL THAT APPLY.

	ARTHRITIS	CANCER (please indicate the type of cancer and location,if pertinent)	DIABETES	HEART ATTACK	HEART DISEASE	HIGH BLOOD PRESSURE	LIVER DISEASE	LUNG DISEASE	OBESITY	SLEEP APNEA	STROKE	CURRENT AGE (if still living)	DEATH – indicate age and cause
MOTHER													
FATHER													
MATERNAL GRANDMOTHER (mother's family)													
MATERNAL GRANDFATHER (mother's family)													
PATERNAL GRANDMOTHER (father's family)													
PATERNAL GRANDFATHER (father's family)													
YOUR SIBLINGS (please indicate for each diagnosis whether it is brother / sister who was affected)													

YOUR SIGNATURE _____ **DATE**_____