MOMENTUM MEDICINE PLUS-*Weightloss*

HEALTH HISTORY FORM **Today's Date:____/____/2014**

All questions contained in this form are confidential and will become part of the patient's medical record.

Name (Last name, First name)_____ □ Male □ Female **DOB:** _____/_____/_____

Primary Care Physician:_____ **Physician Phone#:**_____

Date of last physical exam: _____ **Date of last EKG:**_____ **Significant EKG Findings:**_____

Date of last blood work:_____ **Significant Blood Work findings:** □Cholesterol □Thyroid □High Potassium □Other:_____

How would you rate your overall health? □□ Excellent □□Good □□Fair □□ Poor

PATIENT'S REVIEW OF SYSTEM: *Please check any symptoms you have currently*

Constitutional Symptoms			**Cardiovascular**			**Neurological**		
Fever	□Yes	□ No	Chest Pain	□ Yes	□ No	Headaches	□ Yes	□ No
Chills	□Yes	□ No	Blood Clotting Problem	□Yes	□ No	Dizzy Spells	□ Yes	□ No
Weight Loss/Gain	□ Yes	□ No	Swelling Legs	Yes	□ No	Numbness/Tingling	□ Yes	□ No
Insomnia(trouble sleeping)	□ Yes	□ No	High/Low Blood Pressure	Yes	□ No	Passing out	□ Yes	□ No
Snore	Yes	□ No	**Respiratory**			**Eyes**		
Daytime sleepiness	□ Yes	□ No	Wheezing	□Yes	□ No	Double Vision	□ Yes	□ No
Allergies/Immunological			Frequent Cough	Yes	□ No	Blurred Vision	□ Yes	□ No
Drug Allergies	□ Yes	□ No	Shortness of Breath	□Yes	□ No	**Gastrointestinal**		
Food Allergies	□ Yes	□ No	**Genitourinary**			Nausea/Vomiting	□ Yes	□ No
Endocrine			Trouble getting pregnant	□Yes	□ No	Abdominal pain	□ Yes	□ No
Tired/Sluggish	□ Yes	□ No	Unusual itching/odor	□Yes	□ No	Bloody Stools	□ Yes	□ No
Excessive Thirst	□ Yes	□ No	Unusual vaginal discharge	□Yes	No	Indigestion/Heartburn	□ Yes	□ No
Too Cold	□ Yes	□ No	Urine Retention	□Yes	No	**Psychological**		
Too Hot	□ Yes	□ No	Painful Urination	Yes	No	Do you have problems eating	□ Yes	□ No
Swelling in Feet			Urinary Frequency	Yes	No	Considering Suicide	□ Yes	□ No
Other Problems:_____			Unusual Vaginal Discharge	□ Yes	No	General Satisfaction with your life	□ Yes	□ No
_____						Depression	□ Yes	□No
_____						Anxiety □	Yes	□No

PAST MEDICAL HISTORY

Please check the following conditions that you are currently being treated or have been treated for in the past

Ears/Eye Problems: □ Nose Bleeds □□ Sinus Infections □□ Allergies □ Glaucoma □Cataracts

Gastrointestinal: □Ulcers □Hernia □Acid Reflux □Irritable Bowel Disease (IBS) □Liver □Hepatitis □Gastric Bypass

Genitourinary: □ Erectile Dysfunction □ Frequent UTI's □ Uterine Fibroids □ Bladder Problems □Blood in urine

Reproductive: □ Infertility □ Fibroids □ Uterine Cancer □ Pregnant □ Breastfeeding

Kidney: □ Kidney Failure □ Kidney Cysts □ Kidney Stones

Neurological: □ Headaches □ Migraines □ Seizures □ Brain Tumor □Concussion □ Stroke □ Neuropathy

Skin: □ Rashes □ Boils □ Acne □ Psoriatic Arthritis □ Blisters □ Cellulitis □ Bed Sores

Vascular/Hematological: □ Anemia □ Bleeding Problems □ DVT/Blood Clots □ Cancer □ Leukemia □Varicose Veins

Heart: □ High Cholesterol □High blood Pressure □Low Blood Pressure □ Heart Arrhythmias □ Heart Attack

□CHF(Heart Failure) □ Pacemaker □ Murmur □□Chest Pain/Angina □ Sleep Apnea

Lung/Pulmonary: □ Asthma □ COPD □ Sleep Apnea □ Bronchitis □ Lung Cancer

Endocrine: □ Diabetes □ Hypothyroidism □ Hyperthyroidism □ Obesity □ Overweight □ Excessive Sweating

Infectious Disease: □ HIV/AIDS □ Pneumonia □ STD's □ Tuberculosis □ MRSA □ Lyme Disease

Psychiatric: □Anxiety □Depression □Suicidal Ideation □Bipolar □Schizophrenia □ADHD □Alcoholism □Drug Abuse

Musculoskeletal problems: □ Back pain □□Neck pain □□ Arthritis □ Swollen ankles/feet/arms

□ **Other Medical Problems:**_____

FAMILY HISTORY											
	Normal Weight	Over weight	Obese	Bariatric Surgery	Heart problems	Diabetes	High Blood Pressure	Kidney	Psychiatric Disorder	Stroke	Other
Father											
Mother											
Sister											
Brothers											
Grand parents											

SURGICAL AND HOSPITALIZATION HISTORY			
Surgery	**Date of Surgery**	**Reason for Hospitalization**	**Date of Hospitalization**

Did you have bariatric surgery? □□ No □□Yes **If yes when and where?**_____
How much weight did you lose?_____ lbs

PRESCRIBED MEDICATIONS, OVER-THE-COUNTER DRUGS, AND/OR DIETARY SUPPLEMENTS		
Name of Medication	**Dosage**	**Frequency**

SOCIAL HISTORY

Marital status: □□ Single □□ Married □ □ Divorced □ □ Widowed □ Partner
Employment History: □ Employed. If so, type of work:_____ □ □ Unemployed □Retired □ Disabled

WEIGHT HISTORY

1. **Present Weight (lbs)_____ Height:_____ Desired Weight:_____** (lbs) **Desired time to reach goal weight:_____**
2. **When did you start gaining weight?**_____
3. **What is your main reason to lose weight?**_____
4. **Does your family** (spouse, partner, children,etc) **support you to lose weight and be on weight loss program?** Yes □ No
5. **Is your family overweight or obese?** □ No □Yes. If yes, who? □Spouse □Partner □Parent □Child □Sibling Other:_____
6. **Since the age of 18?** Highest weight?_____ lbs Lowest weight?_____lbs Average weight?_____lbs
7. **Weight loss pattern (from age 18-present):** □□ No pattern □□ Gradual increase of weight over years □ □Sudden increase of weight over few months □□ Sudden increase of weight after pregnancy □□ Variable weight gain and loss while on intermittent diet and exercise "Yo-Yo"

EXERCISE HISTORY

□ Sedentary (little or no exercise) □ □ Lightly active (exercise or sports 1-3 days per week) □ Moderately active (exercise sports 3-5 days/week □□ Very active (exercise/sports 6-7 days/week) □ □ Super active (athlete/training)
If exercise/sports what type?_____

DIET HISTORY

1. **Are you currently dieting?** □□ No □ Yes. If yes, is it a physician supervised diet? □Yes □ □No. Is it a weight loss program with meds? □ □ Yes □ □ No. Is it a non-physician weight loss program? □Yes □□ No
2. **How many meals do you eat p/day?_____.** Do you eat? □□ Breakfast □□Lunch □□Dinner □□ Snacks
3. **Are you a picker**? □Yes □ □ No**. Which meal is the biggest**? □□ Breakfast □□ Lunch □□ Dinner
4. **When you are stressed, do you eat?** □□ More □□ Less □ □ The same
5. **When are you the hungriest**? □ Morning □ □ Lunch □□ Afternoon □□ Dinner □ □ Evening □ □ All the time
   Do you eat right before bedtime? □□ Yes □□ No. What time do you sleep?_____ □ AM □ PM

6. **What type of foods do you eat the most?** □ □Sweets/candy/chocolates □ □ Breads □ □ Pasta □ □ Potatoes □□ Meats □ □Fruits □ □Vegetables □ Other:_____
7. **How many times do you eat at "Fast Food" diner or Restaurant?** □ □ Never □□ Infrequently (less than 1x p/week) □ □Often (2-3x p/week) □ Very frequently (more than 4x p/week)
8. **If so, please name the most frequent one(s)?**_____
9. **Rank type of food intake**: **1)Fat**: □ low □□Moderate □High **(2) Carbohydrates:** □ low □ □ Moderate □□ High **3) Protein**: □ □ Low □ Moderate □□ High
10. **How would you rate your body from 1 (disappointed) to 10 (best/ideal)?_____**
11. **How would you describe your body currently?**_____
12. **What do you think will be your obstacle in your goal of losing weight?**_____
13. **Weight Loss Program History**:

Year	Type of Diet/Weight Loss Program	Were medications Used?	Weight in Ibs at start Of this diet?	Weight Lost on This diet?	How long were You on this Diet?	Name of physican Or Company name who Supervised this diet?
		□Yes □ □ No				
		□Yes □ □ No				
		□Yes □ □ No				
		□Yes □ □ No				
		□Yes □ □ No				

Which diet medications were prescribed in the past? □Adipex 37.5 mg □Fastin 30 mg □ Bontril 105 mg □Bontril PDM □Tenuate 25mg □Tenuate 75mg □Xenical 120 mg □Qsymia 7.5/46mg □Qsymia 15/92mg □Belviq 10mg Other:_____
When did you take appetite suppressants?_____ How long did you take them?_____ Was it successful? □Yes □No
List side effects these medications caused? □None □ Palpitations □Chest pain □Dizziness □Headaches □Other:_____

BEHAVIORAL LIFESTYLE

1. **How would you describe yourself?** □ Always Easygoing, calm and/or "laid back" □Usually easygoing, calm, and/or "laid back" □Once and a while easygoing, calm, and/or "laid back" □Very rarely easygoing, calm, and/or "laid back", but have driven mentality □Never easygoing, calm, and/or "laid back" but have driven and focused mentality □Can never relax

SMOKING HISTORY

Do you smoke? □Yes □No If yes, how many packs per day? □ 1 □ 2 □ 3
How long have you smoked ? _____yrs. If not smoking, when did you quit?_____. If you smoke, do you want to quit: □Yes □No

ALCOHOL HISTORY

Do you drink alcohol? □□Yes □No If yes, what kind? □□ Beer □□ Liquor □□ Wine □□ Mixed drinks
How much do you drink p/week? □□0-1 □□2-5 □□ 6-10 □□ greater than 10. How long have you been drinking ? _____yrs

ILLEGAL DRUG HISTORY

Do you currently (within past 1 year) use recreational or street drugs? □□Yes □□No

CAFFEINE HISTORY

Do you drink caffeinated beverages? □□No □Yes. **If yes, do you drink?** □□ **Coffee** : How many cups p/day?_____
□□ **Tea/IceTea/Green Tea:** How many cups p/day/_____ □□ **Regular Soda:** How many 12oz cans per day?_____ □
□ **Diet Sodas**: How many 12oz cans p/day?_____ □ **Energy Drinks** (Red Bull,etc): How many cans p/day?_____

FEMALES ONLY

1. **1st Day of last Menstruation?_____. Are you pregnant?** □Yes □ No. **Are you breastfeeding?** □ □Yes □ □ No
2. **Are you planning to get pregnant soon?** □□ Yes □□ No. **If so when?_____**
3. **Are you on hormone replacement therapy?** □No □Yes,what?_____. **Are you on Birth Control pills or devices?** □No □Yes,what?_____. **Are you aware that you can not take diet meds if pregnant/breast feeding or planning to get pregnant while on diet pills?** □□ Yes □□ No
4. **Reproductive History:** # of pregnancies_____. # of normal vaginal deliveries_____ . # of normal C-sections_____
5. 1st pregnancy_____ (year)_____lbs gained □ 2nd pregnancy_____ (year)____lbs gained □ 3rd pregnancy_____ (year)_____lbs gained

VERIFICATION OF MEDICAL HISTORY INFORMATION

I acknowledge that on the information I have written above is true and accurate to the best of my knowledge.
Signature:_____ Date: ____/____/2014