Health History

Name: Date:

Date of Birth: Ethnicity:

What are your expectations from treatment? Please be specific.

Do you have any allergies? (Please list)

Please list ALL medications you are currently taking (prescribed and over the counter).

Drug: Dosage: Why:

Please list all vitamins, herbs, supplements (prescribed and over the counter)

Medical History: (Please Circle)

Cardiovascular: AFib, Congestive heart failure, High Blood Pressure, Pulmonary Embolism, Stroke, Varicose veins, Heart palpitations

Pulmonary: Asthma, Difficulty breathing, Sleep Apnea, Ever been told you snore

*__Please fill out Epworth Sleepiness scale Form__

Neurologic: High blood Pressure in the Brain, Nerve entrapment (carpel tunnel etc.), Seizure disorders

Musculoskeletal: Altered center of gravity, Impaired balance, Immobility, Lower back pain, Myalgias, Osteoarthritis, Fibromyalgia, Accidents, Broken bones

Endocrine: Acanthosis Nigricans, Diabetes, Insulin resistance/ Metabolic Syndrome, Decreased HDL (good cholesterol), High cholesterol, High triglycerides,

Gastrointestinal: Cholelithitis, GERD, Glomerulopathy, Hernias, Nephrolithitis, urinary incontinence, pelvic prolaspe

Integument: Carbuncles, Cellulitis, Bacterial or fungal skin fold infections, Skin tags, Stretch marks, Discolored skin from poor circulation, Unwanted or excessive hair growth (facial etc.)

Psycho/ Social: Tiredness, Anxiety, Body image dissatisfaction, Depression, Diminished sex drive, Eating disorders, Experienced bullying, Feeling unmotivated, Hopelessness, Impaired intimacy and sexual relationships, PTSD, Work absenteeism or decreased work production

*__Please fill out Patient Health Questionnaire (PHQ-9)__

Any Cancers:

Anything else?

GYN History:

Number of pregnancies: _____

Birth Control: _____

GYN: Any history of: PCOS, infertility, Difficulty getting pregnant, history of reproductive assistance, heavy, irregular, or painful periods, missed or not having periods, diabetes when pregnant, Preeclampsia, endometriosis, Adenomyosis

Other: _____

Past surgical History: _____

Serious Accident/ Injuries? _____

Social History: Please Circle

Significant others**:** Tobacco use: yes/ no, ETOH: yes/ no, Illicit drug use: yes/ no

Employment: Exercise: yes/ no

Feels safe: yes/ no Support at home: yes/ no

Family History: Please Circle

Any serious or weight-related diseases?

Mother: Father: Sister: Sister 2: Brother: Brother #2:

Paternal Grandmother: Paternal Grandfather: Maternal Grandmother: Maternal Grandfather:

Nutritional History: Please Circle

***Please fill out 24 -Hour Diet Recall Form**

Eat: Breakfast Lunch Dinner

Behavior History:

Cravings	Yes	No
Triggers	Yes	No
Binge Eat	Yes	No
Night Eating	Yes	No
Emotional Eating	Yes	No
Cook at Home	Yes	No
Eat Fast-Food	Yes	No
Eat at Restaurants	Yes	No
Support System	Yes	No
History of Abuse	Yes	No
Ever tried to hurt yourself	Yes	No

Physical Activity History:

Exercise	Yes	No
Work	Yes	No
Goals	Yes	No
Barriers	Yes	No

Health Maintenance: Please circle and write in date

PAP Mammogram Colonoscopy

_____

Date Date Date