

**Patient Information & History Form**

**Patient Information**

\*\*\*PLEASE PRINT CLEARLY\*\*\*

Last Name		First Name:		Middle Initial:	
Street Address:				Date of Birth:	
City:		State:		Zip:	
Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Email:			
Home Phone:		Work Phone:		Cell Phone:	

**Emergency Contact Information**

Last Name:		First Name:		Relationship:	
Home Phone:		Work Phone:		Cell Phone:	

**Medical History**

Primary Care Physician		Date of Last Physical	
Please list <b>ALL medications</b> and <b>dosage</b> you are taking, including prescription, herbal and over-the-counter medications	<input type="checkbox"/> None		
Please list <b>ALL drug and food ALLERGIES</b> , including prescription, herbal and over-the-counter medications:	<input type="checkbox"/> None		

**Surgeries/Hospitalizations**

Previous Major Surgeries and/or Hospitalizations	<input type="checkbox"/> No Major Surgeries/Hospitalizations		
	<input type="checkbox"/> Appendix Removal <input type="checkbox"/> C-Section <input type="checkbox"/> Gall Bladder Removal <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Knee Surgery <input type="checkbox"/> Lung Surgery	<input type="checkbox"/> Breast Augmentation <input type="checkbox"/> Sinus Surgery <input type="checkbox"/> Tonsillectomy <input type="checkbox"/> Tubal Ligation <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospitalization (reason) _____ <input type="checkbox"/> Hospitalization (reason) _____ <input type="checkbox"/> Hospitalization (reason) _____

**Conditions**

Do you suffer from any of these conditions?	<input type="checkbox"/> No Previous Medical Conditions				
	<input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Anorexia/Bulimia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma	<input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Bladder Infections <input type="checkbox"/> Cancer <input type="checkbox"/> COPD <input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> GERD <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Kidney Problems <input type="checkbox"/> Seizures <input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Stress <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid - Hyper <input type="checkbox"/> Thyroid - Hypo <input type="checkbox"/> Ulcers
List any other known conditions					

**Women Only**

Women ONLY	First Day of Last Menstruation	Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you entered Menopause? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you experience abnormal periods? <input type="checkbox"/> Yes <input type="checkbox"/> No	Other

**Family History**

Does anyone in your immediate family suffer from any of these conditions?	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Sudden Death (<40) <input type="checkbox"/> Yes <input type="checkbox"/> No
	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Other

**Health Habits and Lifestyle**

Exercise	<input type="checkbox"/> Sedentary (little or no exercise)	<input type="checkbox"/> Lightly active (light exercise/sports 1/3 days/week)	<input type="checkbox"/> Moderately active (moderate exercise/sports 3/5 days/week)	<input type="checkbox"/> Very active (hard exercise/sports 6-7 days/week)	<input type="checkbox"/> Extra active (very hard exercise/sports & physical job or 2x training)
Caffeine	<input type="checkbox"/> None	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tea	<input type="checkbox"/> Pop	# of cups/cans per day? _____
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kind?			How many drinks per week? _____
Tobacco	Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what kind?			How much per day? _____
Drugs	Do you use recreational or street drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Dietary History**

1. Record all weight loss attempts starting with your first diet through your most recent attempt.  
 2. If you have tried weight-loss medications also, include the type of diet plan you followed (e.g. low fat, 1200 calorie, etc.) while receiving the medication.

Year	How long were you on this diet?	Weight lost on this diet	Type of Diet/Weight Loss Program	Weight Loss Medication Used	Doctor or Dietician who supervised this diet

I certify to the best of my knowledge that the information listed above is complete, true and accurate. I agree PicMed shall rely and act upon this information in making medical decisions about my weight loss treatment

Signature:		Date:	
------------	--	-------	--

