Integra Health and Wellness
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 is affect your life and health?
_____
_____
_____
_____
_____

Weight History
When did you first notice that you were gaining weight?
▫ Childhood ▫ Teens ▫ Adulthood ▫ Pregnancy ▫ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? _____
How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

Life events associated with weight gain (check all that apply):
▫ Marriage ▫ Divorce ▫ Pregnancy ▫ Abuse ▫ Illness
▫ Travel ▫ Injury ▫ Nightshift work ▫ Job change ▫ Quitting smoking ▫ Alcohol ▫ Drugs
▫ Medication (please list:
_____)

Previous weight-loss programs (check all that apply):
▫ Weight Watchers ▫ Nutrisystem ▫ Jenny Craig ▫ LA Weight Loss ▫ Atkins
▫ South Beach ▫ Zone diet ▫ Medifast ▫ Dash diet ▫ Paleo diet
▫ HCG diet ▫ Mediterranean diet ▫ Ornish diet ▫ Other:
_____

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):
▫ Phentermine (Adipex) ▫ Meridia ▫ Xenecal/Alli ▫ Phen/Fen
▫ Phendimetrazine (Bontril) ▫ Topamax ▫ Saxenda ▫ Diethylpropion

▫ Bupropion (Wellbutrin) ▫ Belviq ▫ Qsymia ▫ Contrave
Other (including supplements):
_____
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: _____ What beverages do you drink?
_____
Do you get up at night to eat? Y / N If so, how often? _____ times
List any food intolerances/restrictions:
_____
Food triggers (check all that apply):
▫ Stress ▫ Boredom ▫ Anger ▫ Insomnia ▫ Seeking reward
▫ Parties ▫ Eating out ▫ Other: _____

Food cravings:
▫ Sugar ▫ Chocolate ▫ Starches ▫ Salty ▫ Fast food
▫ High fat ▫ Large portions
Favorite foods:
_____

Medical History

Exercise type:
_____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising?
_____

How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (check all that apply):
▫ Heart attack ▫ Angina ▫ Gallbladder stones ▫ Sleep apnea
▫ High blood pressure ▫ Stroke ▫ Indigestion/reflux ▫ Thyroid
▫ High cholesterol ▫ Diabetes ▫ Celiac disease ▫ Anxiety
▫ High triglycerides ▫ Gout ▫ Pancreatitis ▫ Depression
▫ Infertility ▫ Arthritis ▫ Polycystic Ovarian Syndrome ▫ Bipolar
▫ Glaucoma ▫ Cancer (type/s):
_____
Have you ever been diagnosed with an eating disorder? Y / N If yes, which one?
_____

Past surgical history (check all that apply):
▫ Gastric bypass ▫ Gastric banding ▫ Gastric sleeve ▫ Gallbladder ▫ Heart bypass
▫ Hysterectomy ▫ Other:
_____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):
_____ _____ _____
_____ _____ _____
_____ _____

Allergies:
(Medications)_____
_____
(Food)_____
_____

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

Family History
Obesity (check all that apply): ▫ Mother ▫ Father ▫ Sister ▫ Brother ▫ Daughter ▫ Son
Diabetes (check all that apply): ▫ Mother ▫ Father ▫ Sister ▫ Brother ▫ Daughter ▫ Son
Other (check all that apply): ▫ High blood pressure ▫ Heart disease ▫ High cholesterol
▫ High triglycerides ▫ Stroke ▫ Thyroid problems ▫ Anxiety ▫ Depression
▫ Bipolar disorder ▫ Alcoholism ▫ 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)

▫ Recent weight loss more than 10 pounds

▫ Recent weight gain more than 10 pounds

▫ Acne	▫ Skin rash	▫ Cough
▫ Snoring	▫ Shortness of breath	▫ Chest pain
▫ Difficulty breathing when flat	▫ Fainting/Blacking out	▫ Palpitations
▫ Swelling ankles/extremities	▫ Abdominal pain	▫ Bloating
▫ Constipation	▫ Diarrhea	▫ Food intolerance
▫ Dysphagia/difficulty swallowing	▫ Indigestion	▫ Nausea/vomiting
▫ Increased appetite	▫ Decreased appetite	▫ Heartburn
▫ Gas and bloating	▫ Urinary frequency/urgency	▫ Slow urine flow
▫ Nighttime urination	▫ Blood in stools	▫ Back pain (upper)
▫ Back pain (lower)	▫ Joint pain	▫ Muscle aches/pain
▫ Dizziness	▫ Headaches	▫ Seizures
▫ Weakness/low energy	▫ Anxiety	▫ Depression
▫ Insomnia	▫ Memory loss	▫ Inability to concentrate
▫ Mood changes	▫ Nervousness	▫ Loss of interest
▫ Cold intolerance	▫ Excessive sweating	▫ Hair changes
▫ Heat intolerance	▫ Blood clots	▫ Fatigue/tiredness

(Women only)

▫ Absence of periods	▫ Hot flashes	▫ Change in bladder habits
▫ Abnormal/excessive menstruation	▫ Facial hair	

Comments:

_____

_____

_____

_____