PATIENT MEDICAL HISTORY FORM

Name on Health Card:	______	Appointment Date:	______
Date of birth:	______	Home phone:	______
E-mail address:	______	Cell Phone:	______

How did you hear about the Weight Management Clinic:

- ☐ friend / co-worker — is your friend / co-worker a patient of the clinic? ☐ Yes ☐ No
- ☐ family member — is your family member a patient of the clinic? ☐ Yes ☐ No
- ☐ internet ☐ family doctor ☐ phone book
- ☐ other (please describe): ______

Social History:

Marital Status: ☐ Single ☐ Married

Is your spouse/partner overweight? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

If yes, how many children do you have? ______

How many of your children are overweight? ______

Profession: ______

Employment: ☐ 1. Homemaker ☐ 4. Retired ☐ 2. Unemployed ☐ 5. Disability ☐ 3. Volunteer

☐ 6. Part-Time ______

☐ 7. Full-Time ______

Education level (voluntary):

☐ 1. Less than high school ☐ 3. College

☐ 2. High school or GED ☐ 4. University

Self-Rated Health: Would you say your health in general is:

☐ 1. Excellent ☐ 2. Very Good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

Self-Rated Weight: How do you consider your weight?

☐ Obese ☐ Overweight ☐ About the right weight ☐ Under Weight

Ethnic Background (Voluntary):

- ☐ A. White / Caucasian
- ☐ B. South Asian (ex. Indian, Pakistani)
- ☐ C. East Asian (ex. Chinese, Korean)

D. Black:

- ☐ D1. African Black
- ☐ D2. West Indie Black
- ☐ D3. African American / Canadian

- ☐ E. Aboriginal
- ☐ F. Other, please specify: ______

Please list any ALLERGIES to medications: ______ or ☐ None

Please list all current medications/supplements that you are taking below: (***you may attach a separate sheet)

Name of Medication	Strength (i.e. 500 mg)	Frequency (i.e. Once daily)
	/	/
	/	/
	/	/
	/	/
	/	/

Full Name: ____________________

Have you ever HAD or have been told you HAVE any of the following? Please check any medical conditions that apply:

CARDIOMETABOLIC:

- ☐ High Blood Pressure diagnosed by MD
- ☐ High Cholesterol diagnosed by MD
- ☐ Borderline / Pre diabetes diagnosed by MD
- ☐ Diabetes: ☐ Type 1 ☐ Type 2
  On insulin: ☐ Yes ☐ No

What year were you diagnosed with diabetes? ________

Do you go to a diabetes clinic? ________

Do you see an endocrinologist or internist (diabetes doctor) at the diabetes clinic? ☐ Yes ☐ No

Does your family doctor run a diabetes clinic? ☐ Yes ☐ No

What do you use to treat your diabetes? (please check)

☐ Pills ☐ Insulin ☐ Diet controlled

Do you have any complications due to your diabetes?

☐ Yes ____________________ or ☐ No

If you have diabetes, please check the following:

Are your blood sugars under control? ☐ Yes ☐ No

Do you take your own blood sugars? ☐ Yes ☐ No

If yes, how often? ____________________

Are you seen by an eye doctor? ☐ Yes ☐ No

☐ Gestational Diabetes ☐ Yes ☐ No

☐ Kidney disease ☐ Yes ☐ No

☐ Heart Disease ☐ Angina ☐ Heart Failure

☐ Heart Attack? Year: ____________________

Are you followed by a Cardiologist/Cardiac Specialist?

☐ Yes ☐ No

If yes, who: ____________________

☐ Stroke (or TIA's) Year: ____________________

MECHANICAL:

- ☐ Obstructive Sleep Apnea
- ☐ Using CPAP machine
- ☐ Osteoarthritis
  Joint(s): ____________________
- ☐ Hypothyroidism
- ☐ Cancer Type: ____________________
  Treatment: ________ Year: ________
- ☐ Deep Vein Thrombosis, DVT (blood clot in the leg)
- ☐ Pulmonary Embolism, PE (blood clot in the lungs)

GASTROINTESTINAL

- ☐ Gallstones ☐ Gallbladder removed Year: ________
- ☐ Fatty Liver
- ☐ GERD (heartburn)
- ☐ Crohn's
- ☐ Ulcerative Colitis
- ☐ IBS (Irritable Bowel Syndrome)
- ☐ Other Bowel Conditions: ____________________

PSYCHOLOGICAL

- ☐ Depression diagnosed by MD
- ☐ Anxiety Disorder diagnosed by MD
- ☐ Bipolar Disorder diagnosed by MD
- ☐ Binge Eating Disorder diagnosed by Psychiatrist

Polycystic Ovarian Syndrome (PCOS) Questionnaire (Women only)

Have you ever been diagnosed with PCOS by an MD? ☐ Yes ☐ No

If yes, did this include fertility? ☐ Yes ☐ No

Full Name: ____________________

Obstructive Sleep Apnea (OSA) Questions

Do you snore loudly? ☐ Yes ☐ No

Have you ever been told that you stop breathing, or have pauses in breathing during the night? ☐ Yes ☐ No

If you answered yes to any of the above 2 questions, you will need to fill out the *OSA questionnaire*

Please List all Specialist that you see (i.e.: nephrologist, psychiatrist, endocrinologist, etc):

____

____

____

Operations and Hospitalizations:

☐ Weight Loss Surgery (Gastric Bypass/ Gastric Sleeve/Lap Band) Year: ________ Surgeon's Name: ____________

☐ Heart Surgery Year: ________ Surgeon's Name: ____________

☐ Knee Replacement Year: ________ Surgeon's Name: ____________

☐ Hip Replacement Year: ________ Surgeon's Name: ____________

Please add any additional medical problems or surgeries in the space below:

Medical Problem	Surgery or Procedure	Date of Surgery

Family History:

Please check all that apply in regards to your family members (please **only** indicate: Mother, Father, Brother, Sister):

☐ Overweight/Obese ☐ Heart Attack/Disease ☐ Diabetes

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

Smoking:

☐ Current: Packs/Day: ____________ ☐ Quit Year: ________ ☐ Never Smoked

Alcohol Use:

☐ Yes Drinks/Day or Month: ____________ ☐ No

Full Name:____

Weight History:

What are your main reasons for weight loss? ☐ To improve health ☐ Mobility ☐ Esthetics/Appearance

☐ Other ____

Was there an event triggering weight gain? (Pregnancy, injury, arthritis, medications?)

☐ No ☐ Yes: ____

What was your MAXIMUM weight since age 18 (not counting pregnancy)____________________

What was your LOWEST weight since age 18? ____________________

Have you lost weight and regained it? ☐ Yes ☐ No

If yes, number of times you lost: ____ 5lbs ____ 10lbs ____ 25lbs ____ 50lbs ____ 100lbs

Age at which you were first considered overweight:

☐ 1-5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ Over 60

Have you tried any of the following methods in attempts to lose weight?

☐ Self-directed diet ☐ Self-directed exercise ☐ Personal Trainer/Gym Membership

☐ Diet Book (Atkins, South Beach, Dr. Phil etc.) ____________________

☐ Structured Program (Weight Watchers, Jenny Craig etc.) ____________________

☐ Meal replacement (e.g. Slimfast) or Very low calorie diets (e.g. Optifast) ____________________

☐ Commercial medical programs (e.g. Dr. Bernstein etc.) ____________________

☐ Non-prescription weight loss medications/supplements: ____________________

☐ Prescription weight loss medications: ____________________

☐ Surgery: ____________________

Are you currently in a weight loss program?

☐ No ☐ Yes What program? ____________________

Are you interested in bariatric surgery? ☐ Yes ☐ No ☐ Maybe ☐ Never

Are you currently physically active?

☐ No ☐ Yes How often and what activity? ____________________

How many meals do you eat per day? ____________________

Do you have problems with portion control? ☐ Yes ☐ No

Are you an emotional eater? ☐ Yes ☐ No

Do you wake up at night to eat? ☐ Yes ☐ No

My weaknesses for foods include (check all that apply: ☐ Carbs ☐ Salty ☐ Fat ☐ Sugar

Would you consider yourself a food addict? ☐ Yes ☐ No

I eat fruits and vegetables ☐ Yes ☐ No ☐ Very little

I eat ☐ quickly ☐ slowly

I drink ☐ water ☐ coffee ☐ tea ☐ juice ☐ pop ☐ diet pop

The majority of food intake is ☐ after 6pm ☐ before 6pm

Personal Weight Loss Goals:

What is your ideal ultimate weight goal __________ lbs. What would be a realistic goal weight for you to reach __________ lbs.

At what weight would you still be disappointed __________ lbs.

Behavioural Goals:

Please list a behavioural goal/functional goal that you would like to achieve:

____

____

i.e. decrease my medication, make better food choices when grocery shopping, learn emotional triggers that lead to overeating