Medical Weight Loss Specialists of Bismarck

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New Patient History

(*Please **PRINT** All information clearly*) ***Date:___/___/___***

Name ______________________________ Date of Birth ____/_____/_______ Age _______
Address_____________________________ City/State____________________ Zip_________
Social Security Number: _______/_______/_________

☐Home phone: ( )_____-_______ ☐Work: ( )____- _______ ☐Cell: ( )______-________
Please indicate which phone number you would like for us to use as your primary number
Email address: ____

Occupation:________________________ Employer name: ___________________________
Shifts worked: (Day/PM/Night) ____________________

Primary Physician: _________________________ PCP Phone # ______________________
Preferred Pharmacy: ___________________________ Pharmacy phone: ________________

Lifetime Heaviest Weight (non-pregnant):___________ Age at Heaviest Weight __________
Goal Weight ________________ Age last at Goal Weight _____________
Have you ever had Bulimia, Anorexia, or Binge Eating Disorder? _______________________

Do you Smoke?________ If yes, How much/day? ____________For how many years? ________
How many alcoholic beverages do you consume in a week?______________________________

WOMEN: Are you Pregnant?______________ Are you Breastfeeding?_______________
Are you Menopausal or Premenopausal?____

MEDICATIONS:

Current meds and doses:	**Taking it for**?	**Over the counter meds/vitamins/herbals**
1) _______________________	___________	1) _____________________________
2) _______________________	___________	2) _____________________________
3) _______________________	___________	3) _____________________________
4) _______________________	___________	4) _____________________________
5) _______________________	___________	5) _____________________________
6) _______________________	___________	6) _____________________________
7) _______________________	___________	7) _____________________________
8) _______________________	___________	8) _____________________________
9) _______________________	___________	9) _____________________________
10) ______________________	___________	10) ____________________________

Do you have any Allergies? ____
____

MEDICAL HISTORY:

What serious illnesses have you had in the past? ____

____

What surgeries have you had in the past? ____

____

Please check medical conditions YOU have been diagnosed with in the past or currently:

- ☐ Past or current drug or alcohol problems
- ☐ Depression or anxiety
- ☐ Diabetes: Type 1(juvenile) or 2(adult)?
- ☐ Gestational Diabetes
- ☐ Insulin Resistance/Prediabetes/BorderlineDiabetes/Dysmetabolic Syndrome
- ☐ Polycystic Ovarian Syndrome
- ☐ Heart Burn
- ☐ Glaucoma (Open or Narrow Angle?)
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Heart Disease/Heart Attack/Heart Failure
- ☐ Arrhythmia
- ☐ Heart Valve Problems/ Heart Murmurs
- ☐ Do you have a pacemaker: **YES OR NO**
- ☐ Do you have a defibrillator: **YES OR NO**
- ☐ History of passing out (syncope)
- ☐ Asthma
- ☐ Other Lung diseases: Type:____
- ☐ ADHD (Attention deficit disorder)
- ☐ Bipolarism or other psychiatric conditions? ______________________________
- ☐ Kidney Diseases: Type: ____
- ☐ Liver Diseases: Type: ____
- ☐ Obstructive sleep apnea (use a CPAP?)
- ☐ Insomnia/ other sleep disorders
- ☐ Thyroid Disorders: Low or High or Other: ____________________________
- ☐ Other Chronic Medical Conditions: ________________________________

Please circle if you have been having any of the following symptoms

1) Weakness
2) Dry, Coarse skin
3) Tired/fatigue
4) Slow speech
5) Slow movement
6) Coldness and cold skin
7) Diminished sweating
8) Thick tongue
9) Coarse hair
10) Pale skin
11) Constipation
12) Gain in weight
13) Loss of hair
14) Difficulty breathing
15) Swollen feet
16) Hoarseness
17) Loss of appetite
18) Poor memory
19) Nervousness
20) Heart palpitations
21) Brittle nails
22) Swelling of face & eyelids
23) Excessive/painful menses
24) Emotional Instability
25) Depression
26) Headaches

□ **Please check here if none of the above 26 symptoms apply to you**

WHO in your **FAMILY** has had the following? (mom, dad, siblings, aunts/uncles, cousins, grandparents)

- Heart disease/Heart Attack/Congestive Heart Failure ________________________________
- Cancer (list type) __________________________
- High Cholesterol __________________________
- Sudden death < age 40 from a
- medical condition__________________________
- Diabetes or "borderline diabetes"____________
- Mental illness (depression, bipolar, etc.) ____
- Who in family struggles with weight? ____
- Other family medical conditions _____________________________________
- Hypothyroidism _____________________________________
- High Blood Pressure _____________________________________
- Strokes _____________________________________

EXERCISE:

Frequency?	What is the Intensity?	For how long?
☐ None	☐ None	☐ None
☐ 1-2x/week	☐ Light (brisk walking, golfing, doubles tennis)	☐ Under 10 minutes
☐ 3-5x/week	☐ Moderate (biking, low impact aerobics)	☐ 10-20 minutes
☐ Daily	☐ Moderately hard (running, aerobics, hockey)	☐ 20-30 minutes
	☐ Very hard (Sprinting, speed swimming)	☐ over 30 minutes

Do you have any physical restrictions to exercise? (what are they)__________________________
Do you make yourself sick because you feel uncomfortably full? Y or N
Do you worry you have lost control over how much you eat? Y or N
Have you recently lost more than 15 pounds in a three-month period? Y or N
Do you believe yourself to be fat when others say you are too thin? Y or N
Would you say that food dominates your life? Y or N

What do you hope to accomplish by being here? ____
____

HOW DID YOU HEAR ABOUT THE CLINIC?
Radio (Which station?)__________________ **Magazine** (Which one?) _____________________________
TV Station (Which one?) _______________ Commercial --or-- Interview ___________________________
My doctor's office referred me to you. Dr or PA name: ____
Yellow Pages (Which book?)____________________ **Newspaper Ad** (Which section?) ______________
Internet: Google ___ Yahoo ___ I typed in your website ___ Other?_______________________________
Mailer to the house_________________ **Bulletin** (Which one?)_________________________________
My family member, friend or co-worker who is currently a patient here inspired me to start. *Please share who this was so we can say thank you to them. Their name please:*__________________________________
Other____