Wellness First
WEIGHT MANAGEMENT CENTER

GENERAL INFORMATION & MEDICAL HISTORY

Name: _____ Date: _____ / _____ / _____
Last First MI

Address: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____ (cell) _____

Email: _____ SSN: (last 4 digits) _____ DOB: _____ / _____ / _____

Marital Status: ◯ Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed

Occupation: _____ Employer: _____

Medical Insurance Company: _____

Physician: _____ Phone: _____ Referred by: _____

MEDICATIONS

List medications/supplements you are presently taking, including dose and frequency:

Prescription Drugs	Over-the-Counter Drugs	Vitamins/Nutritional Supplements

List any medications you are sensitive/allergic to:

_____

MEDICAL HISTORY

Select all of the following conditions that you have now or have ever had:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Irregular Heartbeat
- ☐ Swelling of Ankles & Feet
- ☐ Dizziness
- ☐ Varicose Veins
- ☐ Circulation Deficiency in Legs/Feet
- ☐ Stroke
- ☐ Severe Headaches
- ☐ Seizures or Convulsions
- ☐ Numbness or Tingling
- ☐ Fainting
- ☐ Indigestion
- ☐ Alcoholism/Substance Abuse
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Stomach/Duodenal Ulcer
- ☐ Liver Disease (i.e., Hepatitis)
- ☐ Gallbladder Disease
- ☐ Jaundice
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Thyroid Disease
- ☐ High Cholesterol Level
- ☐ Other: _____
- ☐ Anemia
- ☐ Blood Clotting Problem
- ☐ Gout
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Pain/Swelling of Joints
- ☐ Urinary Tract Infection
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Chronic Cough
- ☐ Asthma
- ☐ Allergies
- ☐ Psychiatric Illness
- ☐ Anxiety
- ☐ Depression

Are you currently being treated for a condition not listed? If yes, please specify: _____

SURGICAL HISTORY

List all operations and dates:

YEAR	OPERATION

FAMILY HISTORY

Please include if there is any history of diabetes, high blood pressure, cancer, or coronary heart disease among relatives in your family.

RELATIVE	IF LIVING, STATE OF HEALTH	AGE	IF DECEASED, CAUSE OF DEATH	AGE
Father				
Mother				
Brothers				
Sisters				
Spouse				
Comments				

GYN HISTORY

(women only)

Age at onset of menstrual cycle: _____ Date of last period: ____/ ____/ ____

Are your periods regular? ◯ Yes ◯ No

Are your taking birth control pills? ◯ Yes ◯ No

Are your taking hormones? ◯ Yes ◯ No

Fluid retention: ◯ Slight ◯ Moderate ◯ Severe

If not menstruating, provide age of menopause: _____

If you are presently experiencing menopause, are you having any symptoms? ◯ Yes ◯ No

If yes, describe symptoms: _____

Signatures: _____ _____

(Patient) (Physician)