Patient Information Form/Medical History Form

Patient Name: (Last)_____(First)_____(MI)____
Name you prefer to be called:_____
Birthday:_____ Age:_____Sex: F M Marital Status:_____
Address:_____
City:_____State:_____Zip:_____
Best number to contact you:_____ **Can we leave a message**?_____
Email address: _____
Would you like be reminded about your appointments by phone or email?_____
How did you hear about us?_____
Are you currently involved in other weight loss groups or internet sites?_____
Current Medications(what/dosages):

_____
_____
_____
_____

Do you have any allergies to any medications? _____

Employment Information:

Patient Employer: _____Occupations: _____
Employer Address: _____
City: _____State: _____Zip:_____
Work phone No.:_____Ext:_____

In Case of Emergency
1.Name:_____Relationship:_____Phone:_____
2.Name:_____Relationship:_____Phone:_____
Family Physician_____ Phone:_____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

Financial Policy:

Thank you for selecting Dr. Kelley for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made. For your convenience, we accept Visa, MasterCard, Discover, American Express and checks.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court costs.

I have read and understand all of the above and have agreed to these statements.

_____ _____

Patient's Signature Date

Present Status:

How would you describe your health? Excellent_____Very Good_____Good_____

How often do you weigh yourself: Present Weight:_____Ideal Weight_____

List routine exercise **AND** how often:_____

How many hours of TV/Computer do you average each day?_____hours

How many meals do you eat each day on average?_____meals

How often do you eat out?_____Times a week_____Rarely

Do you drink alcohol? Yes No
What?_____How much?_____Weekly?_____

How many sodas (12 oz. each) do you drink in a day?_____Diet_____Regular

How many glasses of sweetened tea or cups of coffee do you drink per day?_____

How may glasses of water per day?_____glasses

Do you eat when you are bored? Yes No

Do you wake up at night and eat? Yes No

Do you binge eat (feel compelled to eat because of stress)? Yes No

Have you ever used laxatives, diuretics or vomiting for weight control? Yes No

Are you under a doctor's care at the present time? Yes No
If yes, for what? _____

Have you ever been treated with prescription medication for weight loss? Yes No
If yes, when was the last time?_____
If yes, which of the following medications:

____Phentermine (Adipex, Fastin, lonamin
____Benzphetamine (Didrex)
____Diethylopropion (Tenuate)
____Phendimetrizine (Bontril)
____Sibutramine (Meridia)
____Phen-Fen (*see below)
____Xenical
____Other:_____

*If you have taken Phen-fen, have you been told of the cardiac risks?*____Yes____No

Gynecologic History:
When was your last menstrual period?_____date_____not applicable

Serious Injuries: Yes No
Specify: _____ Date: _____

Any Surgery: Yes No
Specify: _____ Date: _____
Specify: _____ Date: _____

Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Past Medical History: (check all that apply)

_____Heart Disease
_____Chest Pain
_____Hypertension
_____Depression
_____Thyroid Disorder
_____Menstrual Dysfunction
_____Diabetes
_____Fibromyalgia
_____Chronic Fatigue
_____Heart Valve Disorder
_____Gallbladder Disorder
_____Psychiatric Illness
_____Alcohol Abuse
_____Cancer
_____Arthritis
_____Osteoporosis

_____Swelling Feet
_____Diabetes
_____Headaches
_____Migraines
_____Constipation
_____Glaucoma
_____Gastrointestinal Problems
If yes, please specify:_____
_____Eating Disorder:
If yes, please specify:_____
Other:_____

Nutrition Evaluation:

In what time frame would you like to be at your desired weight? _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (Give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when?_____

Previous diets you have followed:	Give dates and results of your weight loss:
_____	_____
_____	_____

Is your spouse, fiancee or partner overweight? Yes No

By how much is he or she overweight? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

Smoking Habits: **(answer only one)**

_____You have never smoked cigarettes, cigars or a pipe.
_____You quit smoking ___ years ago and have not smoked since.
_____You smoke 20 cigarettes per day (1 pack).
_____You smoke 30 cigarettes per day (1-1/2 packs).
_____You smoke 40 cigarettes per day (2 packs).

Typical Breakfast	Typical Lunch	Typical Dinner
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Activity Level: **(answer only one)**

_____Inactive— no regular physical activity with a sit-down job.
_____Light activity—no organized physical activity during leisure time.
_____Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____Heavy activity— consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

Behavior style: **(answer only one)**

_____You are always calm and easygoing.
_____You are usually calm and easygoing.
_____You are sometimes calm with frequent impatience.
_____You are seldom calm and persistently driving for advancement.
_____You are never calm and have overwhelming ambition.
_____You are hard-driving and can never relax.

Please describe your general health goals and improvements you wish to make:

Please use the space below for any additional information you feel the physician should know.