

## 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: \_\_\_\_\_

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### **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 many 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, Ionamin)      \_\_\_ Benzphetamine (Didrex)  
\_\_\_ Diethylpropion (Tenuate)                      \_\_\_ Phendimetrazine (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:

Specify: \_\_\_\_\_ Yes No  
Date: \_\_\_\_\_

Any Surgery:

Specify: \_\_\_\_\_ Yes No  
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, fiancée 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.**