

Smith County Family Medical, LLC

PATIENT MEDICAL HISTORY FORM — NEW PATIENT



Name: _____

DOB: _____ Sex: M F

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

How did you hear about us? _____

Present Status: Current weight _____ Height _____

Are you in good health at the present time to the best of your knowledge? Yes No

Explain a "no" answer: _____

Are you under a doctor's care at the present time? Yes No

If yes, for what? _____

Do you have a Pacemaker _____ Neurostimulator _____ Any other medical implanted device _____

Prescription Drugs: List all

Drug:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Over-the-Counter medications, vitamins, supplements: List all

Product:	Dosage:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use Only:

Date: _____

Chart # _____

Goal _____

Weight: _____

Start Weight _____

Chest: _____

Waist: _____

Hip: _____

Waist/Hip Ratio: _____

Reviewed by: _____

Any allergies to any medications? Foods? Yes No

Please list: _____

History of High Blood Pressure? Yes No

History of Diabetes? Yes No At what age: _____

History of Heart Attack or Chest Pain or other heart condition? Yes No

History of Swelling Feet? Yes No

History of Frequent Headaches? Yes No

Migraines? Yes No Medications for Headaches: _____

History of Constipation (difficulty in bowel movements)? Yes No

History of Glaucoma? Yes No

History of Sleep Apnea? Yes No

If "yes", do you wear your CPAP? Yes No

Gynecologic History:

Pregnancies

Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: _____

Onset: _____

Duration: _____

Are they regular: Yes No

Pain associated: Yes No

Last menstrual period: _____

Birth Control Method: _____

Any Surgery: Yes No

Specify: (List all)	Date
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: (please note if anyone had a sudden death under 45 years old)

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

Review of Systems: (Check all that apply)

- General: Fatigue Night Sweats Unexplained weight change
Eyes: Visual trouble Trouble with eye pressure Eye redness/discharge
Ears: Difficulty hearing Ringing in ears
Nose: Chronic discharge/drainage
Throat: Sore throat Difficulty swallowing
Lungs: Wheezing Shortness of breath Snoring Asthma Waking gasping for breath
Chest/Heart: Chest pain Palpitations Irregular heartbeat History of Rheumatic fever
Hematology: Easy bruising Trouble with blood clotting Nose bleeds Miscarriage(s)
GI: Abdominal pain Nausea Vomiting Heartburn Change in bowel habits or stool constipation/diarrhea
Bladder: Kidney stones Urinary frequency/urgency Blood in urine Prostate issues
Circulation: Varicose veins Leg swelling
Musculoskeletal: Back pain Joint pain
Neurology: Headaches Dizziness Passing out Migraines Stroke
Allergy: Hives Rash Itchiness
Sleep: Trouble falling asleep Trouble staying asleep Snoring Never feel rested
Psychiatric: Depression Anxiety Bipolar

Past Medical History: (check all that apply)

Have you ever participated in a medical weight loss program? Yes No
Have you ever taken appetite suppressants or medications to help with weight loss? Yes No

Yes/no checkbox

- | | | | | |
|--|--|---|--|----------------------------------|
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Scarlet |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Fever | <input type="checkbox"/> Chicken |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Pox | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Psychiatric Illness | |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Seizure Disorder | |
| <input type="checkbox"/> Typhoid Fever | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood Clot | <input type="checkbox"/> Thyroid cancer | |
- Atrial Fibrillation/Dysrhythmia

Other: _____

Nutrition Evaluation

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

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

Previous diets/medication you have done: _____

Who lives in your home? _____

Is your spouse, fiancée or partner overweight? Yes No

Are your children overweight? Yes No

How often do you eat "fast foods?" _____

Food allergies: _____

Food dislikes: _____

Food(s) you crave: _____

Do you drink coffee or tea? Yes No How much daily? _____

Do you drink cola drinks? Yes No

How much daily? _____

Do you drink alcohol? Yes No

What? _____ How much daily? _____ Weekly? _____

Do you use a sugar substitute? Yes No Butter? Yes No Margarine? Yes No

Do you awaken hungry during the night? Yes No What do you do? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

When you are under a stressful situation at work or family related, do you tend to eat more? Yes No

Explain: _____

Do you think you are currently undergoing a stressful situation or an emotional upset? Yes No

Explain: _____

Smoking Habits: (answer only one)

You have never smoked You quit smoking years ago You smoke __ cigarettes per day

Typical Breakfast: _____ Time Eaten: _____

Where: _____ With whom: _____

Typical Lunch: _____ Time Eaten: _____

Where: _____ With whom: _____

Typical Dinner: _____ Time Eaten: _____

Where: _____ With whom: _____

What is your current exercise routine? _____

Any exercise limitations? _____

Mental Health

Have you ever been diagnosed or treated for Anxiety or Depression? Yes No

Have you ever been treated or diagnosed with an Eating Disorder? (Anorexia, Bulimia, Binge Eating) Yes No

Night Eating Syndrome? Yes No

Do you panic when stressed? Yes No

Do you cry frequently? Yes No

Have you ever attempted suicide? Yes No

Have you ever seen a counselor? Yes No

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

Goal Weight: _____

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. By signing this form,

I am indicating all health history is accurate and correct.

Signed: _____ Date: _____