



Patient Health History Form

Patient's Name _____ Age _____ Date _____

When did you first become overweight? (your age then) _____ (year) _____

How did your weight gain start? Describe any circumstances: _____

What do you think is the cause of your weight problem?

Your present weight: _____ **your weight goal:** _____ height: _____

What was your highest weight? (excluding pregnancy) _____ your age then _____

of years ago _____

What was your lowest weight? _____ your age then _____ # of years ago _____

Have you ever stayed the same weight for 10 years or more? Yes:/ No

Have you attempted to lose weight before? _____ most lbs lost: _____ how long it took: _____ Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture). And describe your results: _____

Where and when do you do most of your overeating? _____

Please make any comments that you think might be helpful:

Do you currently have any medical concerns? Please List:

Past History:

- Birth defects or abnormalities Exposed to tuberculosis Measles
- Influenza Mumps Diphtheria Rheumatic Fever
- Fever German Measles (3 day) Polio whooping cough Frequent colds
- Chickenpox Tonsillitis Scarlet Fever Pneumonia
- Diabetes:Type: _____ Cancer, Type:_____

Other Diseases _____ Operations:(dates)_____

Current Medications (please include over the counter medications)

Allergies to medicines, foods, etc.

Do you Drink Alcohol _____ If so, How much _____ Do you Smoke _____ If so, How many packs a day _____

Family History:

Father: Health _____ Age _____ Deceased _____ at age _____ Cause _____
 Mother: Health _____ Age _____ Deceased _____ at age _____ Cause _____
 # of siblings: _____ # living _____ #deceased: _____ Cause _____

Family Diseases: Check diseases known in your blood relatives (not yourself)

- High blood pressure Allergy Heart trouble Anemia
- Migraine Bleeding (abnormal) Heart Failure Epilepsy
- Strokes Cancer Diabetes Depression
- Kidney disease Suicide Obesity
- Arthritis Rheumatic Fever
- Other _____

Examinations:

Date of last physical examination _____ Reason _____

Hospitalizations, Dates and Reasons:_____

Do you now have or have had any of the following?

- Itching Eczema Hives Joint pain Muscle aches

- Arthritis Limitation of motion Backache Leg pains Heel Pains
- Pain or stiffness (neck) Goiter Swelling, enlarged glands
- Lung disease Emphysema Bronchitis
- High blood pressure Shortness of breath Palpitation or fluttering
- Lips or nails turn blue Tire easily Swelling of ankles Indigestion
- Nausea or vomiting Abdominal pain Gas or bloating Diarrhea
- Hard bowel movements Colitis
- Jaundice Hemorrhoids (piles) Bleeding or black stools Hernia
- Kidney disease Bladder disease
- Painful urination Pus or blood in urine Albumen or sugar in urine
- Varicose veins Nervousness or anxiety Trouble sleeping Headaches
- Bored or depressed Fainting Seizures
- Numbness Loss of consciousness Neuritis or Neuralgia Paralysis

Menstrual History:

Menstruation began at age _____ 28 day cycle? _____ If no, how many days? _____

LMP: _____

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

Patient's Signature

Date

Patient Information

Patient Name: (Last) _____ (First) _____ (MI) _____
Name you prefer to be called: _____ e-mail: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Beeper/Cellular: _____
Birthdate: _____ Age: _____ Sex: M F
Education: Elementary High School/Technical School 2-yr College 4-yr College
Graduate School (Circle the highest level achieved)

Employment Information:

Patient Employer: _____ Occupation: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Work phone No: _____ Ext. _____
Social Security: _____ Drivers License: _____

In Case of Emergency:

Name: _____ Relationship: _____ Phone: _____
Patient's Spouse: _____ Phone: _____
Family Physician: _____ Phone: _____
Referred by: _____

Financial Policy:

Thank you for selecting **Conway Cosmedic** for your weight loss program provider.. 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.**

All statements on this patient intake form are accurate and true to the best of my knowledge. I understand that treatments will be based on the information provided herein.

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

Patient's Signature

Date