

The Center for Medical Weight Loss

9401 Centreville Road, Suite 203

Manassas, VA 20110

703-361-3232

Date: _____

Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Cell Phone: _____

Best Number to Reach You: _____ May We Leave A Message Yes No

E-Mail: _____

Primary Care Physician: _____

How Did You Hear About Us? _____

Past Medical History: Please Check All the Apply.

- | | | | | | |
|---------------|--|-----------------------|--|-------------------|--|
| Measles | <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough | <input type="checkbox"/> Yes <input type="checkbox"/> No | Back Trouble | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mumps | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bladder infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemorrhoids | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chickenpox | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Scarlet Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diphtheria | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headaches | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Smallpox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pneumonia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bleeding Tendency | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hives or Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No | AIDS or HIV | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Infectious Mono | <input type="checkbox"/> Yes <input type="checkbox"/> No | Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood or Plasma | | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Transfusions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Any other disease | |

Date of Last Chest X-ray: _____

Previous Hospitalizations/Surgeries/Serious Illness: _____ When? _____ Hospital, City, State _____

Medications: (Include nonprescription) _____

Medical Notes:

Review of Systems: Have you experienced any of the following symptoms? Respond to each.

Constitutional Symptoms

- Good General Health Yes No
- Recent Weight Change Yes No
- Fever Yes No
- Fatigue Yes No
- Headaches Yes No

Eyes

- Eye disease Yes No
- Wear glasses/contacts Yes No
- Blurred or double vision Yes No

Ear/Nose/Mouth/Throat

- Hearing loss or ringing Yes No
- Earaches or drainage Yes No
- Chronic Sinus problem Yes No
- Nose bleeds Yes No
- Mouth sores Yes No
- Bleeding gums Yes No
- Bad breath/Bad taste Yes No
- Sore throat/voice change Yes No
- Swollen glands in neck Yes No

Cardiovascular

- Heart trouble Yes No
- Chest pain Yes No
- Palpitation Yes No
- Shortness of breath w/walking/lying flat Yes No
- Swelling of feet/ankles Yes No

Respiratory

- Do you have a persistent Cough or throat clearing (lasting more than 3 weeks) Yes No
- Spitting up blood Yes No
- Shortness of breath Yes No
- Wheezing Yes No

Genitourinary

- Frequent Urination Yes No
- Burning or painful urination Yes No
- Blood in Urine Yes No
- Change in force of strain when urinating Yes No
- Incontinence or dribbling Yes No
- Kidney stones Yes No
- Sexual Difficulty Yes No
- Male - Testicle pain Yes No
- Female-Pain with periods Yes No
- Female-irregular periods Yes No
- Female-vaginal discharge Yes No
- Female-# of pregnancies _____
- Female-# of miscarriages _____
- Female-date of last pap smear _____

Musculoskeletal

- Joint pain Yes No
- Joint stiffness/swelling Yes No
- Weakness of muscles/joints Yes No
- Muscle pain or cramps Yes No
- Back pain Yes No
- Cold extremities Yes No
- Difficulty in walking Yes No

Integumentary (skin/breast)

- Rash or itching Yes No
- Change in skin color Yes No
- Change in hair or nails Yes No
- Varicose veins Yes No
- Breast pain Yes No
- Breast lump Yes No
- Breast discharge Yes No

Neurological

- Frequent headaches Yes No
- Light headed/dizzy Yes No
- Convulsions/seizures Yes No
- Numbness/tingling sensation Yes No
- Tremors Yes No
- Paralysis Yes No
- Head injury Yes No

Psychiatric

- Memory Loss or Confusion Yes No
- Nervousness Yes No
- Depression Yes No
- Insomnia Yes No

Endocrine

- Glandular or hormone problem Yes No
- Excessive thirst or urination Yes No
- Heat or cold intolerance Yes No
- Skin becoming dryer Yes No
- Change in hat/glove size Yes No

Hematologic/Lymphatic

- Slow to heal after cuts Yes No
- Bleeding/Bruising tendency Yes No
- Anemia Yes No
- Phlebitis Yes No
- Past transfusion Yes No
- Enlarged glands Yes No

Allergic/Immunologic

- History of skin reaction or other adverse reaction to:
 - Penicillin or other antibiotics Yes No
 - Morphine, Demerol or other narcotics Yes No
 - Novocain or other anesthetics Yes No
 - Aspirin/other pain remedies Yes No
 - Tetanus or other serums Yes No
 - Iodine, Merthiolate, etc. Yes No
 - Other drugs/medicine _____
- Known Food Allergies _____

Gastrointestinal

- Abdominal pain Yes No
- Loss of appetite Yes No
- Change in bowel movement Yes No
- Nausea or vomiting Yes No
- Frequent diarrhea Yes No
- Painful bowel movement or constipation Yes No
- Rectal bleeding/blood in stool Yes No

Medical Notes

Have you ever taken Fen-Phen/Redux? Yes No

Patient Social History:

Marital Status: Single Married Separated Divorced Widowed
Use of Alcohol: Never Rarely Moderate Daily
Use of Tobacco: Never Previously, but Quit Current packs/day: _____
Use of Drugs: Never Type/Frequency _____

Family Medical History

Age	Diseases	If Deceased, Cause of Death
Father _____	_____	_____
Mother _____	_____	_____
Siblings _____	_____	_____
_____	_____	_____
_____	_____	_____
Spouse _____	_____	_____
Children _____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

