Serenity MedSpa
AND METABOLIC WEIGHT MANAGEMENT CENTER

NEW PATIENT MEDICAL HISTORY FORM

Name: (First)_____ (Last) _____ (MI)____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight affect your life and health? _____
_____
_____

Weight History

When did you become overweight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ Nightshift work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: _____
What worked? _____
What didn't work? _____
Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____

Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____
Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____
Eating triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _____

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: _____

Medical History
Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____

How many hours do you sleep per night? _____ How times do you get up during the night? _____
Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gall bladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux arthritis	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ Polycystic Ovarian Syndrome		

☐ Cancer (type/s): _____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications and dosages):
_____ _____ _____ _____
_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

Social History
Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ Never ☐ Current user (_____ times/day)

Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____

Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Recent weight loss more than 10 pounds
☐ Recent weight gain more than 10 pounds
☐ Acne ☐ Skin rash ☐ Cough
☐ Snoring ☐ Shortness of breath ☐ Chest pain
☐ Difficulty breathing when flat ☐ Fainting/Blacking out ☐ Palpitations
☐ Swelling ankles/extremities ☐ Abdominal pain ☐ Bloating
☐ Constipation ☐ Diarrhea ☐ Food intolerance
☐ Dysphagia/difficulty swallowing ☐ Indigestion ☐ Nausea/vomiting
☐ Increased appetite ☐ Decreased appetite ☐ Heartburn
☐ Gas and bloating ☐ Urinary frequency/urgency ☐ Slow urine flow
☐ Nighttime urination ☐ Loss of urine control ☐ Blood in stools
☐ Back pain (upper) ☐ Back pain (lower) ☐ Joint pain
☐ Muscle aches/pain ☐ Dizziness ☐ Headaches
☐ Seizures ☐ Weakness/low energy ☐ Anxiety
☐ Depression ☐ Insomnia ☐ Memory loss
☐ Inability to concentrate ☐ Mood changes ☐ Nervousness
☐ Loss of interest ☐ Cold intolerance ☐ Excessive sweating
☐ Hair changes ☐ Heat intolerance ☐ Blood clots
☐ Fatigue/tiredness

(Women only)

☐ Absence of periods ☐ Hot flashes ☐ Change in bladder habits
☐ Abnormal/excessive menstruation ☐ Facial hair ☐ Loss of interest in sex
☐ Difficulty getting pregnant

Comments: _____

Signature_____Date:_____

Provider Initials:_____