13000 Harbor Center Drive, #202, Woodbridge, VA, 22192
Tel: 703-955-5355 Fax: 703-955-5348

NEW PATIENT MEDICAL HISTORY FORM

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

Weight History

When did you first notice that you were gaining weight?

☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause

Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, when? _________

How much did you weigh: one year ago? _____ Five years ago? _____ 10 years ago? _____

Life events associated with weight gain (check all that apply):

☐ Marriage ☐ Divorce ☐ Pregnancy ☐ Abuse ☐ Illness
☐ Travel ☐ Injury ☐ Nightshift work ☐ Job change ☐ Quitting smoking
☐ Alcohol ☐ Drugs
☐ Medication (please list: ____)

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? ______________________________________
____

How does your weight affect your life and health? ______________________________________
____
____

Have you ever taken medication to lose weight? (check all that apply):

☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen ☐ Semaglutide
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion ☐ Vegovy
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave ☐ Mounjaro
☐ Ozempic

Other (including supplements): ____
What worked? ____
What didn't work? ____
Why or why not? ____

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Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____ What beverages do you drink? ___________________________
Do you get up at night to eat? Y / N If so, how often? _____ times
List any food intolerances/restrictions: ____
Food triggers (check all that apply):

☐ Stress ☐ Boredom ☐ Anger ☐ Insomnia ☐ Seeking reward
☐ Parties ☐ Eating out ☐ Other: ________________________

Food cravings:

☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ Fast food
☐ High fat ☐ Large portions
Favorite foods: ____

Medical History

Exercise type: ____
Duration: _____ hours _____ minutes Number of times per week: _____
Does anything limit you from exercising? ____

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

Past medical history (check all that apply):

☐ Heart attack ☐ Angina ☐ Gallbladder stones ☐ Sleep apnea
☐ High blood pressure ☐ Stroke ☐ Indigestion/reflux ☐ Thyroid
☐ High cholesterol ☐ Diabetes ☐ Celiac disease ☐ Anxiety
☐ High triglycerides ☐ Gout ☐ Pancreatitis ☐ Depression
☐ Infertility ☐ Arthritis ☐ Polycystic Ovarian Syndrome ☐ Bipolar
☐ Glaucoma ☐ Cancer (type/s): ____
Have you ever been diagnosed with an eating disorder? Y / N If yes, which one? _________________

Past surgical history (check all that apply):

☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gallbladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: ____

Medications (list all current medications, including over-the-counter medications, supplements, and herbs):

_____________________ _____________________ _____________________ _____________________
_____________________ _____________________ _____________________ _____________________

Allergies:
(Medications)____
(Food)____

OPTIMAL SLEEP & WEIGHT LOSS CLINIC

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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
☐ Snoring
☐ Difficulty breathing when flat
☐ Swelling ankles/extremities
☐ Constipation
☐ Dysphagia/difficulty swallowing
☐ Increased appetite
☐ Gas and bloating
☐ Nighttime urination
☐ Back pain (lower)
☐ Dizziness
☐ Weakness/low energy

☐ Skin rash
☐ Shortness of breath
☐ Fainting/Blacking out
☐ Abdominal pain
☐ Diarrhea
☐ Indigestion
☐ Decreased appetite
☐ Urinary frequency/urgency
☐ Blood in stools
☐ Joint pain
☐ Headaches
☐ Anxiety

☐ Cough
☐ Chest pain
☐ Palpitations
☐ Bloating
☐ Food intolerance
☐ Nausea/vomiting
☐ Heartburn
☐ Slow urine flow
☐ Back pain (upper)
☐ Muscle aches/pain
☐ Seizures
☐ Depression

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☐ 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

Comments: ____

____

____

Comments:

____

____

Signature: ________________________ Date: _______________