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LM Medical Center
11010 N Dale Mabry Hwy, Suite 102. ¨ Tampa, FL 33618 ¨ Phone: (813) 443-5390 ¨ Fax: (813) 443-5391

Patient Name: ____________________ **DOB:** __________ **Today's Date:** __________

Allergies: ____________________ **Weight:** __________ **Goal Weight:** __________

Last physical: __________ **Last EKG:** __________ **Last eye exam:** __________

HEALTH HISTORY **COMPLETE TO THE BEST OF YOUR KNOWLEDGE**

O	Alcohol abuse	O	Depression	O	Glaucoma	O	Migraines
O	Anemia	O	Diabetes	O	Headaches	O	Moodiness
O	Arthritis	O	Diarrhea	O	Heart Disease	O	Nervousness
O	Asthma	O	Dizzy Spells	O	High Cholesterol	O	Obesity
O	Bleeding Disorder	O	Drug Abuse	O	Hypertension	O	Palpitations
O	Bloody Stool	O	Eating Disorder	O	Insomnia	O	Rashes
O	Bronchitis	O	Epilepsy	O	Irregular Pulse	O	Shortness of Breath
O	Cancer	O	Fainting Spells	O	Kidney Disease	O	Stroke
O	Chest Pain	O	Fatigue	O	Liver Disease	O	Thyroid Disease
O	Constipation	O	Frequent Urination	O	Lung Disease		
O	Convulsions	O	Gallbladder Disorder	O	Mental Illness		

HOSPITALIZATIONS

YEAR	REASON/DIAGNOSIS	HOSPITAL

SURGICAL HISTORY

PAST PROCEDURES / OPERATIONS	MONTH / YEAR

PRESCRIPTION MEDICATION, OVER-THE-COUNTER DRUGS, DIETARY SUPPLIMENTS (vitamins, inhalers,etc.)

MEDICATION NAME	STRENGTH	FREQUENCY

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BEHAVIOR STYLE		PLEASE MARK ONLY ONE ANSWER
O You are always calm and easygoing.	O You are usually calm and easygoing.	O You are sometimes calm and easygoing.
O You are seldom calm and persistently driving for advance.	O You are never calm and have overwhelming ambition.	O You are hard-working and never relax.

HEALTH HABITS & PERSONAL SAFETY					THIS SECTION IS OPTIONAL
Exercise	O Sedentary (No exercise)				
	O Mild Exercise (i.e., climbing stairs, walking three blocks, golf)				
	O Occasional vigorous exercise (i.e., work or recreation less than 4 times per week for 30 minutes or more)				
	O Regular vigorous exercise (i.e., work or recreation 4 times per week for 30 minutes or more)				
Diet	Are you dieting?			O Yes	O No
	If yes, are you on a physician-prescribed medical diet?			O Yes	O No
	How many meals do you eat in an average day?				
	Rank your salt intake:		O High	O Medium	O Low
	Rank your fat intake:		O High	O Medium	O Low
Caffeine	Rank your caffeine intake:	O High	O Medium	O Low	O None
	What type of caffeine do you drink?		O Coffee	O Tea	O Soda
	How many cups/cans per day?				
Alcohol	Do you drink alcohol?			O Yes	O No
	If yes, what kind?		O Beer	O Liquor	O Wine
	How many drinks per week?				
Tobacco	Do you use tobacco?			O Yes	O No
	O Cigarettes—packs/day:	O Chew—#/day:	O Pipe—#/ day:	O Cigars—#/day:	
	How many years?				
	If you previously used tobacco, what year did you quit?				
Drugs	Do you currently use recreational or street drugs?			O Yes	O No
	Have you ever taken street drugs with a needle?			O Yes	O No

WOMEN ONLY *** It is import that you do not get pregnant or breast feed while using any diet medications.			
How old were you at onset of menstruation?	Date of last menstruation?	# of pregnancies:	# of births:
Heavy periods, irregularity, spotting, pain, or discharge?		O Yes	O No
Is there any chance you are pregnant?		O Yes	O No
Are you breast feeding?		O Yes	O No

PRIOR WEIGHT LOSS PROGRAM

PRIOR MEDICATIONS: SUCCESSES, FAILURES, SIDE-EFFECTS

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WEIGHT HISTORY

1. What is the main reason you decided to lose weight?

2. When did you begin gaining excess weight (give reason f known)?

3. What do you think is the main cause of your weight problems?

4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.

5. Is your spouse, fiancé, or partner overweight?

6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?

7. List any food allergies:

8. What foods do you avoid?

9. What foods do you crave?

10. Do you awaken hungry during the night?

11. What are your worst food habits?

12. What are your snack habits?

13. Rate your body from 1 to 10. How would you describe your body?

14. If you could change one thing about your body, what would it be?

15. What do you feel will be your obstacle(s) to successful weight loss?

16. What is your typical breakfast? What time? Where? With whom?

17. What is your typical lunch? What time? Where? With whom?

18. What is your typical dinner? What time? Where? With whom?

19. Add any additional comments you think would be helpful to the doctor.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time in patients in completing this form.

Print name: ___________________________________ **Signature:** ___________________________________ **Date:** _______________