Total Weight Loss Center

2790 Clay Edwards Dr., Ste. 600
North Kansas City, MO 64116

Health History

Patient Name: _____ **Date of Birth:** _____

CURRENT MEDICATIONS: (Include laxatives, herbal supplements and vitamins)

Name	Strength (e.g. mg dose)	Formulation (e.g. liquid, tablet, or capsule	Dose (i.e. how many, e.g. 1 tab)	Frequency (e.g. once daily)

Year of last Pneumovax: _____ **Year or Last Flu:** _____

Preferred/Pharmacy & Location: _____

LIST OF ALLERGIES (Please include type of reaction)

Are you allergic to **shellfish or iodine?** YES or NO

Allergic to **Latex**? YES or NO

Drug	Reaction

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SOCIAL HISTORY:

Marital Status: (Circle One):	**Married**	**Single**	**Widowed**	**Divorced**	**Partner**
Your Occupation:				**How Long:**	
Do you use Tobacco now?	**Yes or No**	**Past?**	**Type/Amount?**	**How Long?**	
Do you drink alcohol now?	**Yes or No**	**Type?**	**Frequency**	**How Long?**	
Do you use chemical substances now? (circle one)	**Yes or No**			**Past? Tes or No**	

Hobbies: _____

*** Please answer yes or no to whether you have experienced any of these symptoms within the past 6 months.**

Constitutional Symptoms
Y N Fatigue
Y N Weight Loss
Y N Fever
Y N Chills
Y N Night Sweats

Eye Symptoms
Y N Vision Problems
Y N Blurry Vision
Y N Seeing Double

Ear Symptoms
Y N Loss of Hearing
Y N Ringing in Ears
Y N Earache
Y N Ear Discharge

Nose & Throat Symptoms
Y N Nasal Discharge
Y N Nasal Congestion
Y N Sinus Pressure
Y N Sinus Pain
Y N Sore Throat
Y N Hoarseness
Y N Allergies
Y N Nosebleeds (epistaxis)

Pulmonary Symptoms
Y N Cough
Y N Cough up Sputum
Y N Blood
Y N Shortness of Breath
Y N Wheezing
Y N Asthma

Cardiac Symptoms
Y N Chest Pain
Y N Edema
Y N Palpitations

Gastric Symptoms
Y N Decreases in Appetite
Y N Heartburn
Y N Difficulty in Swallowing
Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Abdominal Pain
Y N Rectal Bleeding
Y N Black Stools

GU Symptoms
Y N Urinary Frequency
Y N Urinary Incontinence
Y N Painful Urination
Y N Blood in Urine
Y N Nocturia (urination >2x per night)

Musculoskeletal Symptoms
Y N Joint Pain
Y N Muscle Aches
Y N Muscle Weakness
Y N Lower Back Pain

Neurological Symptoms
Y N Numbness
Y N Tingling
Y N Headache
Y N Dizziness
Y N Syncope
Y N Convulsions

Skin Symptoms
Y N Lesions

Breast Symptoms
Y N Discharge
Y N Lump

Endocrine Symptoms
Y N Excessive Thirst
Y N Intolerance to Heat
Y N Intolerance to Cold
Y N Easy Bruising
Y N Swollen glands in the Neck

Psych Symptoms
Y N Depression
Y N Anxiety

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Past Medical History *(circle all that apply)*

Metabolic/Endocrine
Chronic fatigue
High cholesterol
High Triglycerides
Hypothyroidism
Diabetes - Type 1
Diabetes - Type 2
Gout

Urological
Urinary Stress Incontinence
Kidney Disease
Kidney Stones

Cardiovascular
Heart Attack
Heart Murmur
Hypertension/High Blood Pressure
Edema in Lower Extremities
Arrhythmia
Coronary Artery Disease
Congestive Heart Failure
Angina (Chest Pain)
Defibrillator
Pacemaker

Gynecologic *(Women only)*
Menstrual Irregularity
Polycystic Ovarian Syndrome

Neurological
Severe Headaches
Migraine Headaches
Stroke
Seizures

Respiratory
Asthma
Shortness of Breath
CPAP/BIPAP
Sleep Apnea
Snoring
Blood Clot in Lung
Emphysema
Chronic Cough

Hematological
Anemia
Blood Clot in Legs
Bleeding Disorder

Psychiatric
Anxiety
Anorexia/Bulimia
Bipolar Disorder
Depression
Schizophrenia

Gastrointestinal
Severe Heartburn
Cholecystitis/Gallbladder Disease
Hemorrhoids
Hiatal Hernia
Stomach Ulcers
History of Colon Cancer
Irritable Bowel Syndrome
Fatty Liver
Nausea/Vomiting
Diarrhea/Constipation
Cirrhosis/Hepatitis
Pancreatitis
Crohn's Disease

Cancer
Location:_____

Musculoskeletal
Arthritis
Back Pain
Carpal Tunnel Syndrome
Fibromyalgia
Plantar Fasciitis
Single/Multiple Joint Pain
Tingling in Extremities

Other
Hearing Impaired
Vision Impaired

Other Medical History not Listed Above

_____

_____

_____

Surgical History

	Type of Surgery	Month/Year of Surgery
1.		
2.		
3.		
4.		
5.		

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FAMILY HISTORY: PRESENT HEALTH OR CAUSE OF DEATH

	Father	Mother	Sisters	Brothers	Children
Living					
Deceased					
Year of Birth					
Age					
Diabetes					
Hypertension					
Heart					
Stroke					
Mental					
Cancer					
Unknown					
Additional Information					

Self Diets

Name of diet attempted	Approximate time on the diet & year	Amount of weight lost on the diet	Amount of weight regained
Example: Weight Watchers	*6 months in 1993*	*10 lbs.*	*15 lbs.*