Texas Health Hospital Rockwall

Patient Medical History

Patient Name: _____

Allergies: _____

Primary Care Physician: _____ **Phone Number**: _____

Medications

Please list all medications you are currently taking.

Name of Medication	Dosage	Frequency	Indication

Past Surgical History

Please list all surgical procedures and operations.

Procedure	Date	Location	Indication

Family History

Please indicate family members diagnosed with the following illnesses.

	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Siblings	Children
Obesity								
Diabetes								
Hypertension								
Heart Disease								
Cancer								
Seizures								
Asthma								
Arthritis								
Kidney Disease								
Early Death								

How many years have you been overweight? _____

Previous weight loss surgery? ☐ **No** ☐ **Yes, I've had:** _____

Surgery Type	Date	Surgeon	Weight Loss

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Patient Medical History

Patient Name: _____

Diet Programs and Supplements

Please indicate which of the following diets or plans you have attempted.

Program	Dates	Duration	MD Supervised	Weight Loss
Atkins Diet				
Grapefruit Diet				
Herbalife				
Jenny Craig				
Liquid diets				
Medifast				
Metabolife				
Nutri-Systems				
Optifast				
Pritikin Diet				
Slimfast diet				
TOPS				
Weight Watchers				
Other:				

Weight Loss Medications History

Please indicate which of the following medications you have taken.

Medication	Dates	Duration	MD Supervised	Weight Loss
Amphetamines				
Phentermine (Adipex, Fastin, Pondimen)				
Phen-Fen				
Redux (Dexafenaflouramine)				
Xenical (Orlistat)				
Meridia (Sibutramine)				
Other Diet Medication:				

Non-Dietary Therapies

Please indicate if you have attempted any of the following weight loss treatments.

Therapy	Dates	Duration	MD Supervised	Weight Loss
Regular Exercise				
Hypnosis				
Behavior Modification				
Acupuncture				

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Patient Medical History

Patient Name: _____

Social History

Do you use tobacco? ☐ Yes ☐ No **Number of packs per day:** _____ **Number of years smoking:** ____

Do you use alcohol? ☐ Yes ☐ No **Amount & frequency:** _____

Have you ever been treated for depression? ☐ Yes ☐ No

Are you currently in treatment? ☐ Yes ☐ No

If yes, please indicate the name and phone number of your physician or therapist:

_____

Have you ever been hospitalized for mental illness? ☐ Yes ☐ No

System Review

Please circle all that apply.

Constitutional
Fatigue
Tiredness
Recent weight loss
Fever
Night sweats
Abnormal bleeding

Cardiovascular
Chest pain
Pain in arm/neck
Heart attack
Palpitations
Heart pounding
Stroke
Heart murmur
Pain in legs
Cold feet
Loss of pulses
Low blood pressure
High blood pressure
Abnormal heartbeat

Respiratory
Shortness of breath
Asthma
Wheezing
Coughing
Bloody sputum
Emphysema
Pneumonia
Bronchitis
Difficulty sleeping flat
Waking at night
Shortness of breath

Gastrointestinal
Jaundice
Hepatitis
Cirrhosis
Vomiting
Nausea
Heartburn
Abdominal pain
Diarrhea
Constipation
Painful bowel movements
Blood in stools
Hemorrhoids
Change in stool size
Irritable bowel
Colitis

Genitourinary
Blood in urine
Frequent urination
Leakage of urine
Painful urination
Trouble starting urine
Kidney stones
Bladder infection

Musculoskeletal
Painful joints
Swelling of joints
Muscle aches
Arthritis
Pain in hips
Pain in knees
Pain in ankles
Pain in feet
Lower back pain
Herniated disk
Sciatica
Numbness of legs/feet
Abnormal lumps/mass

Neurological
Seizures
Convulsions
Fainting
Vertigo
Light headedness
Falling
Muscle weakness
Numbness
Tremors
Loss of consciousness

Psychological
Depression
Nervousness
Anxiety
Suicidal thoughts
Suicide attempts
Schizophrenia
Anorexia
Bulimia
Binge eating
Hospitalization

Endocrine
Hyperthyroid
Hypothyroid
Goiter
Previous radiation
Diabetes
Adrenal tumors
Previous steroid use
Swollen glands

Skin/Breast
Skin cancer
Abnormal moles
Burns
Rash
Breast mass
Nipple discharge
Mammogram within the last year

Men
Discharge from penis
Loss of erection

Women
Vaginal discharge
Abnormal bleeding
Irregular periods
Hysterectomy
Pap exam within the last year

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Patient Medical History

Patient Name: _____

Obesity Related Medical History

☐ Yes	☐ No	Heart disease	Year of Diagnosis: _____
☐ Yes	☐ No	Angina	Year of Diagnosis: _____
☐ Yes	☐ No	MI (heart attack)	Year of Diagnosis: _____
☐ Yes	☐ No	Coronary Bypass Surgery	Year of Diagnosis: _____
☐ Yes	☐ No	Palpitations (abnormal heartbeat)	Year of Diagnosis: _____
☐ Yes	☐ No	Congestive heart failure	Year of Diagnosis: _____
☐ Yes	☐ No	High blood pressure	Year of Diagnosis: _____
☐ Yes	☐ No	Elevated cholesterol	Year of Diagnosis: _____
☐ Yes	☐ No	Elevated triglycerides	Year of Diagnosis: _____
☐ Yes	☐ No	Asthma	Year of Diagnosis: _____
☐ Yes	☐ No	Reflux	Year of Diagnosis: _____
☐ Yes	☐ No	Heartburn	Year of Diagnosis: _____
☐ Yes	☐ No	Esophagitis	Year of Diagnosis: _____
☐ Yes	☐ No	Hiatal Hernia	Year of Diagnosis: _____
☐ Yes	☐ No	Sleep apnea	Year of Diagnosis: _____
☐ Yes	☐ No	…Do you use a CPAP machine?	
☐ Yes	☐ No	Shortness of breath	
		… You can walk _____ blocks. You can climb ____ flights of stairs.	
☐ Yes	☐ No	Snoring	
☐ Yes	☐ No	Awakening at night	
☐ Yes	☐ No	Daytime drowsiness	
☐ Yes	☐ No	Observed apnea episodes	
☐ Yes	☐ No	Morning headaches	
☐ Yes	☐ No	Venous stasis	
☐ Yes	☐ No	Leg or ankle edema	
☐ Yes	☐ No	Leg ulceration	
☐ Yes	☐ No	Pain of arthritis	
☐ Yes	☐ No	… In ankles	
☐ Yes	☐ No	… in knees	
☐ Yes	☐ No	… in hips	
☐ Yes	☐ No	Limits ability to walk	
☐ Yes	☐ No	Limits ability to exercise	
☐ Yes	☐ No	Low back pain/sciatica	
☐ Yes	☐ No	Diabetes	Year of Diagnosis: _____
☐ Yes	☐ No	… Juvenile onset	Year of Diagnosis: _____
☐ Yes	☐ No	… Gestational (pregnancy)	Year of Diagnosis: _____
☐ Yes	☐ No	… Adult onset	Year of Diagnosis: _____
☐ Yes	☐ No	… Diet controlled	
☐ Yes	☐ No	… Oral medications	
☐ Yes	☐ No	… Insulin dependent	
☐ Yes	☐ No	Urinary incontinence	Year of Diagnosis: _____
☐ Yes	☐ No	… leaking urine with coughing	
☐ Yes	☐ No	… leaking urine with sneezing	
☐ Yes	☐ No	… leaking urine with straining	

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Patient Medical History

Patient Name: _____

Obesity Related Medical History (cont.)

☐ Yes	☐ No	Migraine	Year of Diagnosis: _____
			… Frequency: _____
☐ Yes	☐ No	Deep vein thrombosis	Year of Diagnosis: _____
☐ Yes	☐ No	Pulmonary embolism	Year of Diagnosis: _____
☐ Yes	☐ No	Abdominal wall hernia	Year of Diagnosis: _____
☐ Yes	☐ No	… incisional	
☐ Yes	☐ No	… umbilical	
☐ Yes	☐ No	… number of hernia repairs _____	

Have you ever had:

☐ Yes	☐ No	Blood transfusion	Year of transfusions: _____
☐ Yes	☐ No	Hepatitis	Year of Diagnosis: _____
☐ Yes	☐ No	Exposure to HIV/AIDS	Year of exposure: _____
☐ Yes	☐ No	Abused intravenous drugs	

Preferred Communication

☐ Verbal
☐ Written
☐ Email

Patient's Communication/Learning Barrier's

☐ None	☐ Electronic larynx	☐ Tracheostomy tube
☐ Age	☐ Language barrier	☐ Unable to read
☐ Visual impaired	☐ Mentally impaired	☐ Unable to write
☐ Hearing impaired	☐ Speech impairment	

Past Medical History

Please list all other medical conditions, illnesses, or other important information not previously mentioned:

_____

_____

_____

_____

_____

_____

_____

_____

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