BELAMEDICA

wellness • weightloss

New Patient Information

Name____ Today's Date__________________

Age________________________ Date of Birth____________________________________

Surgeries (please circle all that apply)

None

Appendix: (Reason: infection, other____)?

Breasts: (Reason: non-cancerous cyst, cancer, augmentation, other_________________)?

Cesarean section: (How many C-sections? ______________________________________)?

Eyes: (Reason: cataracts, diabetic retinopathy, other______________________________)?

Gallbladder: (Reason: gallstones, infection, sludge, other__________________________)?

Heart: (Reason: bypass, stent, other____)?

Hysterectomy: (Reason: uterine fibroids, heavy bleeding, anemia, other______________)?

Kidney: (Reason: cysts, cancer, other____)?

Lungs: (Reason: infection, cancer, other____)?

Ovaries: (Reason: cysts, endometriosis, cancer, other_______________________________)?

Prostate: (Reason: enlarged prostate, cancer, other__________________________________)?

Skin: (Reason: non-cancerous lesion, cancer, melanoma, other______________________)?

Other surgeries/hospitalizations: ____

____?

Medical History (please circle all that apply)

Allergies/Sinus Problems
Acne
Anemia
Arthritis/Rheumatism
Asthma/Wheezing
Back Pain (recurrent)
Cancer ______________
Constipation
Depression
Diabetes (meds/insulin?)
Diarrhea
Diverticulitis/Colitis
Gout
Headaches/Migraines
Heart Attack
Heart Murmur
Heart Arrhythmia
High Blood Pressure
High Cholesterol
Heartburn/GERD
Hepatitis
Insomnia
Kidney Stones
Lactose Intolerance
Memory Loss
Numbness/Neuropathy
Osteopenia/Osteoporosis
Prostate (enlarged)
Psoriasis/Eczema
Stroke
Sleep Apnea (C-pap?)
Thyroid Disease
Urinary/Bladder Problems
Other:____________________
____
____
____
____
____

Females only:

Total Number of: Pregnancies______ Births______ Miscarriages______ Abortions______

Facial Hair Fertility Problems Irregular Menstrual Cycle

Premenstrual Syndrome (mood swings, irritability, tension, bloating)

Polycystic Ovary Syndrome (mood swings, irregular menses, weight gain, thin hair, cysts)

Menopause/Perimenopause (irritability, hot flashes, night sweats)

Social History

Occupation____

Children: None If yes, how many? 1 2 3 4 5 6 7 8 9 10 11 12

Tobacco: None

Quit—How many years smoke free?

Active tobacco use—Packs/day____________ Total # years smoked_________

Alcohol: Type____

Average number of drinks____________per week/month/year (circle one)

Family Medical History (please state relation: mother, father, sister, brother, grandparent)

Alzheimer's/Dementia____

Cancer____

Depression____

Diabetes____

Heart Attack____

Heart Disease____

High Blood Pressure____

High Cholesterol____

Overweight/Obesity____

Stroke____

Other significant family medical history____

____

Weight History

How much weight do you want to lose?____

What is an ideal weight for you?____

When was the last time you were at your ideal weight?____________________________

Have you tried other diets/meds/weight loss programs?____________________________

If yes, which ones?____

____

What foods do you crave most?____

What are your worst food habits (snacking, late-night eating, skipping meals, emotional eating, etc)____

What are the main reasons you want to lose weight? (please circle all that apply)

To look better

To feel better

To have more energy

To decrease risk/complications of diabetes, heart disease, high blood pressure, etc.

To see my children/grandchildren grow up

To live longer healthfully

All of the above

Let's get started to discovering a healthier you!!!