



BELAMEDICA

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

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!!!