CHIEFLAND MEDICAL CENTER
Caring for the health of your family

Weight Management Medical History Form

Please fill out completely.

First Name: _____ Last Name: _____

Preferred Name: _____

DOB: _____ Sex: _____ Social Security Number: _____-____-_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Work: _____

Email: _____ Preferred Contact Method: _____

Employer: _____ Preferred Language: _____

Ethnicity: _____ Marital Status: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Who can we thank for referring you to our practice? _____

1113 NW 23rd AVE CHIEFLAND, FL 32626
PHONE 352-493-9500 FAX 866-895-8359

Describe the main reason for your visit today:

_____

_____

_____

How does your weight affect your daily life?

_____

_____

_____

Any other symptoms associated with your chief complaint?

_____

_____

_____

Lowest Weight: _____ When? _____
Heaviest Weight: _____ When? _____

What is your goal weight? _____

What is motivating you to lose weight? _____

What challenges do we need to overcome to reach your goal? _____

_____

Past Weight Loss Programs/plans: (Check all that apply)

- ☐ Weight Watchers
- ☐ Jenny Craig
- ☐ Nutrisystem
- ☐ South Beach / Atkins / Low Carb / KETO
- ☐ Medically Supervised Treatment: (Describe) _____

Social History

Do you smoke? YES NO Past Smoker? YES NO

If yes, # cigarettes per day _____ How long? _____

Do you use smokeless tobacco? YES NO If yes, how long? _____

Do you drink alcohol? YES NO If yes how much? _____

Caffeine Use? YES NO If yes please state amount and frequency _____

Do you exercise? YES NO If yes please describe your exercise habits -

_____

_____

Medical History

Are you allergic to any medication? YES NO If yes, list the medication and reaction -

Please list all medications, vitamins and supplements you currently take

Medication	Dosage	Frequency

Have you been hospitalized or undergone a surgical procedure? YES NO If yes, please list:

Surgery/Illness Date

Any Dietary/Nutrition Restrictions? (Include food allergies)

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Have you ever or are you experiencing any of the following? (Check all that apply)

Constitutional Symptoms

- ☐ Weight Gain _____lbs
- ☐ Weight loss _____lbs
- ☐ Night Swets
- ☐ Fatigue
- ☐ Appetite change

Eyes

- ☐ Glaucoma
- ☐ Vision loss
- ☐ Blurred/Double vision

Ear/Nose/Throat/Mouth

- ☐ Hearing loss
- ☐ Nasal congestion
- ☐ Snoring
- ☐ Mouth/throat irritation
- ☐ Toot problems

Respiratory

- ☐ Shortness of breath
- ☐ Cough
- ☐ Wheezing

Cardiovascular

- ☐ Chest pain/Pressure
- ☐ High/Low blood pressure
- ☐ Heart
- ☐ Heart failure
- ☐ Heart attack
- ☐ Sweating
- ☐ Ankle swelling
- ☐ Syncope/Passing out

Gastrointestinal

- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in stool
- ☐ Liver disease
- ☐ Difficulty swallowing
- ☐ Heartburn

Integumentary

- ☐ Skin rash
- ☐ Dry skin
- ☐ Eczema

Genitourinary

- ☐ Urinary retention
- ☐ Pain with urination
- ☐ Kidney disease
- ☐ Incontinence
- ☐ Urinary frequency
- ☐ Urinary hesitancy
- ☐ Frequent UTI's

Neurological

- ☐ Stroke
- ☐ Insomnia
- ☐ Dizzy
- ☐ Seizures

Hematologic/lymphatic

- ☐ Swollen glands
- ☐ Easy bleeding
- ☐ Anemia
- ☐ DVT

Musculoskeletal

- ☐ Muscle Wasting
- ☐ Arthritis
- ☐ Pain
- ☐ Stiffness
- ☐ Weakness

Endocrine

- ☐ Change in sex drive
- ☐ Cold/Hot
- ☐ Thyroid problems
- ☐ Blood sugar
- ☐ Excessive thirst

Any Family History of: (check all that apply)

- ☐ Anemia
- ☐ Breast Disease
- ☐ Cancer
- ☐ Chronic pain
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Endometriosis
- ☐ Erectile
- ☐ Fractures
- ☐ Gout
- ☐ Glaucoma
- ☐ Heart disease
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hemorrhoids
- ☐ Headache
- ☐ Hepatitis
- ☐ Allergies
- ☐ Hormone disorders
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease
- ☐ Lung disease
- ☐ Neurological
- ☐ Osteoporosis
- ☐ Overactive bladder
- ☐ Obesity
- ☐ Psychological
- ☐ Stroke
- ☐ Stomach ulcer
- ☐ Seizure
- ☐ GERD
- ☐ Sickle cell anemia
- ☐ Sleep disorder
- ☐ Thyroid disease
- ☐ Spine
- ☐ STD's

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If there is anything not listed on this form that you feel your medical provider should be aware of, please list here: _____

_____

- ☐ I, the undersigned, understand that I may choose to take medication for the purpose of appetite suppression and weight loss. I have been advised of the effects and side effects this medication may produce and further advised that if adverse effects are noticed I will stop taking medication and call the clinic ASAP. Clinic hours are Monday thru Friday 8am – 5pm. If an adverse reaction happens outside of clinic hours, I understand that I am to go to the nearest emergency room. I also understand that if I become pregnant, I will stop any and all medications given to me and notify the physician.
- ☐ I do not wish to take any medications for appetite suppression or weight loss.

I agree to submit this medial history as accurately, completely, and to the best of my recollection. I agree that failure to provide truthful, accurate and complete information on this history form to medical providers of Chiefland Medical Center, LLC could result in inappropriate treatment. I also understand that this record submitted will be held in the highest confidentiality as set by the Health Information Act as well as other established law and will only be used to further my medical treatment.

_____ _____ _____

Print Name Signature Date

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WEIGHT LOSS CONSENT FORM

I _____ authorize Chiefland Medical Center LLC and any designated associate or assistants, to help me with my weight reduction efforts. I understand that the success of my weight loss depends upon my effort and there are no guarantees of weight loss or how long I will maintain any weight lost during the weight management program. Obesity may be a chronic condition that requires permanent changes in behavior including dietary and exercise habits to be treated successfully.

My weight loss program may include a reduced calorie diet, exercise program, appetite suppressant medications and instruction in behavior modification. I understand that any weight loss regimen may involve risks as well as benefits. I also understand that there are significant health risks associated with being overweight or obese. Risks of the weight loss program may include but are not limited to fatigue, headaches, trouble sleeping, dry mouth, diarrhea, constipation, anxiety, depression, elevated blood pressure, heart irregularities/arrhythmias and very rarely death. Risks associated with remaining overweight or obese may include elevated blood pressure, diabetes, heart disease, heart attacks, arthritis, cancer, sleep apnea and sudden death.

My weight loss program may include FDA approved appetite suppressant mediations. These medications may be given for longer period of time than recommended by appetite suppressant labeling. I understand that this is considered "off label" and have been informed of risks involved, including risk of heart disease.

My weight loss program may include natural formulations and vitamin products which have not been evaluated by the FDA. In keeping with government regulations, we make no therapeutic or medical claims on these products. I have read and fully understand this consent form. I realize that I should not sign the consent form if all items have not been explained to me. My questions have been answered to my complete satisfaction.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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