The Center for Medical Weight Loss

9401 Centreville Road, Suite 203
Manassas, VA 20110
703.361.3232

Date:_____

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

Address:_____

Phone Number:_____ **Cell Phone:**_____

Best Number to Reach You:_____ **May We Leave A Message?** □ **Yes** □ **No**

E-Mail:_____

Primary Care Physician:_____

How Did You Hear About Us?_____

Past Medical History: Please Check All That Apply.

Measles	□ Yes	□ No	**Whopping Cough**	□ Yes	□ No	**Back Trouble**	□ Yes	□ No
Mumps	□ Yes	□ No	**Bladder Infection**	□ Yes	□ No	**Hemorrhoids**	□ Yes	□ No
Chickenpox	□ Yes	□ No	**High Blood Pressure**	□ Yes	□ No	**Hepatitis**	□ Yes	□ No
Scarlet Fever	□ Yes	□ No	**Low Blood Pressure**	□ Yes	□ No	**Ulcer**	□ Yes	□ No
Diphtheria	□ Yes	□ No	**Migraine Headaches**	□ Yes	□ No	**Epilepsy**	□ Yes	□ No
Smallpox	□ Yes	□ No	**Tuberculosis**	□ Yes	□ No	**Kidney Disease**	□ Yes	□ No
Pneumonia	□ Yes	□ No	**Bleeding Tendency**	□ Yes	□ No	**Asthma**	□ Yes	□ No
Diabetes	□ Yes	□ No	**Thyroid Disease**	□ Yes	□ No	**Arthritis**	□ Yes	□ No
Cancer	□ Yes	□ No	**Hives or Eczema**	□ Yes	□ No	**AIDS or HIV**	□ Yes	□ No
Polio	□ Yes	□ No	**Infectious Mono**	□ Yes	□ No	**Bronchitis**	□ Yes	□ No
Glaucoma	□ Yes	□ No	**Mitral Valve Prolapse**	□ Yes	□ No	**Heart Disease**	□ Yes	□ No
Hernia	□ Yes	□ No	**Blood or Plasma**	□ Yes	□ No	**Rheumatic Fever**	□ Yes	□ No
Stroke	□ Yes	□ No	**Transfusions**	□ Yes	□ No	**Stroke**	□ Yes	□ No
Anemia	□ Yes	□ No	**Venereal Disease**	□ Yes	□ No	**Any other disease**		

Date of Last Chest X-Ray:_____ **Please List:**_____

_____

Previous Hospitalizations/Surgeries/Serious Illness: **When?** **Hospital, City, State**

_____

_____

_____

Medications: (Include Nonprescription)_____

_____

_____

Medical Notes:

_____

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Review of Symptoms: Have you experienced any of the following symptoms? Respond to each.

Constitutional Symptoms
Good General Health ☐ Yes ☐ No
Recent Weight Change ☐ Yes ☐ No
Fever ☐ Yes ☐ No
Fatigue ☐ Yes ☐ No
Headaches ☐ Yes ☐ No

Eyes
Eye disease ☐ Yes ☐ No
Wear glasses/contacts ☐ Yes ☐ No
Blurred or double vision ☐ Yes ☐ No

Ear/Nose/Mouth/Throat
Hearing loss or ringing ☐ Yes ☐ No
Earaches or drainage ☐ Yes ☐ No
Chronic Sinus Problem ☐ Yes ☐ No
Nose Bleeds ☐ Yes ☐ No
Mouth sores ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Bad breath/Bad taste ☐ Yes ☐ No
Sore throat/voice change ☐ Yes ☐ No
Swollen glands in neck ☐ Yes ☐ No

Cardiovascular
Heart trouble ☐ Yes ☐ No
Chest Pain ☐ Yes ☐ No
Palpitation ☐ Yes ☐ No
Shortness of breath w/walking/lying flat ☐ Yes ☐ No
Swelling of feet/ankles ☐ Yes ☐ No

Respiratory
Do you have a persistent Cough or throat clearing (lasting more than 3 weeks)
Spitting up blood ☐ Yes ☐ No
Shortness of breath ☐ Yes ☐ No
Wheezing ☐ Yes ☐ No

Genitourinary
Frequent Urination ☐ Yes ☐ No
Burning or painful urination ☐ Yes ☐ No
Blood in Urine ☐ Yes ☐ No
Change in force of strain when urinating ☐ Yes ☐ No
Incontinence or dribbling ☐ Yes ☐ No
Kidney Stones ☐ Yes ☐ No
Sexual Difficulty ☐ Yes ☐ No
Male- Testicle pain ☐ Yes ☐ No
Female- Pain with periods ☐ Yes ☐ No
Female- irregular periods ☐ Yes ☐ No
Female- vaginal discharge ☐ Yes ☐ No
Female-# of pregnancies _____
Female-# of miscarriages _____
Female-date of last pap smear_____

Musculoskeletal
Joint Pain ☐ Yes ☐ No
Joint stiffness/swelling ☐ Yes ☐ No
Weakness of muscles/joints ☐ Yes ☐ No
Muscle pain or cramps ☐ Yes ☐ No
Back Pain ☐ Yes ☐ No
Cold extremities ☐ Yes ☐ No
Difficulty in walking ☐ Yes ☐ No

Integumentary (skin/breast)
Rash or itching ☐ Yes ☐ No
Change in skin color ☐ Yes ☐ No
Change in hair or nails ☐ Yes ☐ No
Varicose veins ☐ Yes ☐ No
Breast pain ☐ Yes ☐ No
Breast lump ☐ Yes ☐ No
Breast discharge ☐ Yes ☐ No

Neurological
Frequent headaches ☐ Yes ☐ No
Light headed/seizures ☐ Yes ☐ No
Convulsions/seizures ☐ Yes ☐ No
Numbness/tingling sensation ☐ Yes ☐ No
Tremors ☐ Yes ☐ No
Paralysis ☐ Yes ☐ No
Head injury ☐ Yes ☐ No

Psychiatric
Memory Loss or Confusion ☐ Yes ☐ No
Nervousness ☐ Yes ☐ No
Depression ☐ Yes ☐ No
Insomnia ☐ Yes ☐ No

Endocrine
Glandular or hormone problem ☐ Yes ☐ No
Excessive thirst or urination ☐ Yes ☐ No
Heat or cold intolerance ☐ Yes ☐ No
Skin becoming dryer ☐ Yes ☐ No
Change in hat/glove size ☐ Yes ☐ No

Hematologic/Lymphatic
Slow to heal after cuts ☐ Yes ☐ No
Bleeding/Bruising tendency ☐ Yes ☐ No
Anemia ☐ Yes ☐ No
Phlebitis ☐ Yes ☐ No
Past transfusion ☐ Yes ☐ No
Enlarged glands ☐ Yes ☐ No

Allergic/Immunologic
History of skin reaction or other adverse reaction to:
Penicillin or other antibiotics ☐ Yes ☐ No
Morphine, Demerol or other narcotics ☐ Yes ☐ No
Novocain or other anesthetics ☐ Yes ☐ No
Aspirin/other pain remedies ☐ Yes ☐ No
Tetanus or other serums ☐ Yes ☐ No
Iodine, Merthiolate, etc. ☐ Yes ☐ No
Other drugs/medicine_____
_____
Known Food Allergies_____
_____

Gastrointestinal
Abdominal pain ☐ Yes ☐ No
Loss of appetite ☐ Yes ☐ No
Change in bowel movement ☐ Yes ☐ No
Nausea or vomiting ☐ Yes ☐ No
Frequent diarrhea ☐ Yes ☐ No
Painful bowel movement ☐ Yes ☐ No
Or constipation ☐ Yes ☐ No
Rectal bleeding/blood in stool ☐ Yes ☐ No

Medical Notes

_____
_____
_____
_____
_____
_____

Have you ever taken Fen-Phen/Redux? □ **Yes** □ **No**
Patient Social History:

Marital Status:	□ **Single**	□ **Married**	□ **Separated**	□ **Divorced**	□ **Widowed**
Use of Alcohol:	□ **Never**	□ **Rarely**	□**Moderate**	□ **Daily**	
Use of Tobacco:	□ **Never**	□ **Previously, but**	□ **Quit**	□ **Current packs/day:**_____	
Use of Drugs:	□ **Never**	□ **Type/Frequency**_____			

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____