The Orlando Institute of Weight Management & Metabolic Medicine

PATIENT DEMOGRAPHICS

DATE OF BIRTH	AGE	GENDER	SOCIAL SECURITY #
		☐ Male ☐ Female	DO NOT FILL UNLESS NEEDED TO FILL PRESCRIPTION

LAST NAME	FIRST NAME	MI

STREET ADDRESS	CITY	STATE	ZIP	COUNTY

HOME PHONE	WORK PHONE
May we leave a message at this number? ☐ *Yes* ☐ *No*	*May we leave a message at this number?* ☐ *Yes* ☐ *No*
CELL PHONE	**EMAIL ADDRESS**
May we leave a message at this number? ☐ *Yes* ☐ *No*	*May we leave a message at this number?* ☐ *Yes* ☐ *No*

OCCUPATION	EMPLOYER	MARITAL STATUS	SPOUSE NAME (if applicable)

EMERGENCY CONTACT (Last, First)	RELATIONSHIP	PHONE NUMBER

HOW DID YOU LEARN ABOUT OUR PROGRAM?

PATIENT WEIGHT HISTORY

HEIGHT		WEIGHT		GOAL WEIGHT	
HOW LONG HAVE YOU BEEN TRYING TO LOSE WEIGHT?					
WHAT WAS YOUR HEAVIEST WEIGHT?			WHAT AGE AT THAT WEIGHT?		
WHEN DID YOU FIRST BECOME OVERWEIGHT?					
WHAT DO YOU THINK IS THE CAUSE OF YOUR WEIGHT PROBLEM?					
ARE ANY MEMBERS OF YOUR HOUSEHOLD OVERWEIGHT? (If yes, please list relation)					
WHAT WAS YOUR MOTIVATION FOR JOINING OUR PROGRAM?					

HAVE YOU PARTICIPATED IN ANY OF THE FOLLOWING WEIGHTLOSS PROGRAMS? (CIRCLE ALL THAT HAVE DONE)			
Weight Watchers	Jenny Craig	Slim Fast	Atkins
South Beach	NutriSystem	Transformations	**Other:**

DO YOU EXERCISE?		IF YES, HOW OFTEN?	NEVER RARELY DAILY 4-5 times/wk 2-3 times/wk

WHAT TYPES OF EXCERCISES DO YOU DO? CIRCLE ALL THAT APPLY			
Walking	Swimming	Dancing	Elliptical
Treadmill/jogging	Bicycling	Yoga/Pilates	Weight training
Stairmaster	Sports (basketball, tennis, etc.)	Aerobics	Other
DESCRIBE THE DURATION OF YOUR EXERCISE ROUTINE (time)			

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PATIENT MEDICAL HISTORY

MEDICATIONS (Please list the medications you are currently taking, and needed)		
MEDICATION NAME	DOSAGE & FREQUENCY	THIS MEDICATION IS FOR (LIST DISEASE)

ARE YOU ALLERGIC TO ANY FOODS OR MEDICATIONS? IF NO, WRITE NONE. IF YES, LIST FOOD AND/OR MEDICATION ALONG WITH THE ADVERSE REACTION YOU HAD

FAMILY HISTORY (If blood relative has suffered the following, please indicate relationship)			
Abnormal Lung Function		Stroke	
Obstructive Sleep Apnea		Cataracts	
Fatty Liver Disease		Glaucoma	
Gall Bladder Disease		Thyroid Disease	
Abnormal Periods		Heart Attack	
Infertility		PreDiabetes	
Polycystic Ovarian Syndrome		Diabetes	
Arthritis		High Cholesterol	
Gout		High Blood Pressure	
Intracranial Hypertension		Other Diseases?	

HAVE YOU EVER BEEN HOSPITALIZED? IF YES, WHEN AND WHY?	
Year	Illness or operation

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CIRCLE YES OR NO TO EACH OF QUESTIONS BELOW:

CONSTITUTIONAL SYMPTOMS			**RESPIRATORY**			**HEMATOLOGIC/LYMPHATIC**		
Good general health lately	No	Yes	Chronic or frequent coughs	No	Yes	Slow to heal after cuts	No	Yes
Recent weight change	No	Yes	Spitting up blood	No	Yes	Bleeding or bruising tendency	No	Yes
Fever	No	Yes	Shortness of breath	No	Yes	Anemia	No	Yes
Fatigue	No	Yes	Asthma or Wheezing	No	Yes	Phlebitis	No	Yes
Headaches	No	Yes				Enlarged glands	No	Yes
CARDIOVASCULAR			**MUSCULOSKELETAL**			**INTEGUMENTARY** (skin, breast)		
Heart trouble	No	Yes	Joint pain	No	Yes	Rash or itching	No	Yes
Arrhythmia or abnormal rhythm	No	Yes	Joint stiffness or swelling	No	Yes	Change in skin color	No	Yes
Chest pain or angina pectoris	No	Yes	Weakness of muscles or joints	No	Yes	Change in hair or nails	No	Yes
Palpitation	No	Yes	Muscle pain or cramps	No	Yes	Varicose veins	No	Yes
Shortness of breath	No	Yes	Back Pain	No	Yes	Breast pain	No	Yes
Swelling of feet, ankles or hands	No	Yes	Cold extremities	No	Yes	Breast lump	No	Yes
			Difficulty in walking	No	Yes	Breast discharge	No	Yes
NEUROLOGICAL			**GASTROINTESTINAL**			**GENITOURINARY**		
Frequent or recurring headaches	No	Yes	Loss of appetite	No	Yes	Frequent urination	No	Yes
Light headed or dizzy	No	Yes	Change in bowel movements	No	Yes	Burning or painful urination	No	Yes
Convulsions or seizures	No	Yes	Nausea or vomiting	No	Yes	Blood in urine	No	Yes
Numbness or tingling sensations	No	Yes	Frequent diarrhea	No	Yes	Change in force of strain when urinating	No	Yes
Tremors	No	Yes	Painful bowel movements or constipation	No	Yes	Incontinence or dribbling	No	Yes
Paralysis	No	Yes	Rectal bleeding or blood in stool	No	Yes	Kidney stones	No	Yes
Stroke	No	Yes	Abdominal pain	No	Yes	**EARS/NOSE/MOUTH/THROAT**		
Head Injury	No	Yes	Peptic ulcer *(stomach or duodenal)*	No	Yes	Hearing loss or ringing	No	Yes
						Earaches or drainage	No	Yes
PSYCHIATRIC			**ENDOCRINE**					
Memory loss or confusion	No	Yes	Pre-Diabetes/Insulin Resistance	No	Yes	Chronic sinus problem or rhinitis	No	Yes
Nervousness/Anxiety	No	Yes	Thyroid disease	No	Yes	Nose bleeds	No	Yes
Depression	No	Yes	Diabetes (*insulin or non-insulin*)	No	Yes	Mouth sores	No	Yes
Insomnia (difficulty sleeping	No	Yes	Excessive thirst or urination	No	Yes	Bleeding gums	No	Yes
EYES			Heat or cold intolerance	No	Yes	Bad breath or bad taste	No	Yes
Eye disease or injury	No	Yes	Skin becoming dryer	No	Yes	Snoring/Sleep Apnea	No	Yes
Wear glasses/contact lenses	No	Yes				Use a Sleep Apnea machine?	No	Yes
			OTHER: LIST DISEASES HERE:					
Glaucoma	No	Yes						

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Food and Drink Diary

Please let us know what you typically eat and drink throughout the day.

Meal	Foods	Drinks
Breakfast	____________________________	______________________________
Snack	____________________________	______________________________
Lunch	____________________________	______________________________
Snack	____________________________	______________________________
Dinner	____________________________	______________________________
Snack	____________________________	______________________________

Are you an emotional eater? YES NO

Do you drink alcohol? NO YES

HOW OFTEN? ____

Do you smoke? NO YES
 # PER DAY _____

What are some things that trigger your hunger?

____