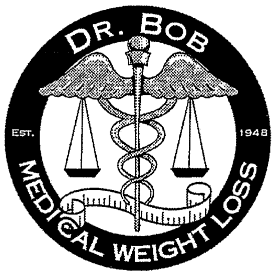

DR. BOB MEDICAL WEIGHT LOSS CENTERS

□Altoona
□Johnstown
□Somerset
□Uniontown

PATIENT HISTORY

DATE:

HISTORY FORM

Name *(print)* ______________________________

Address ______________________ DOB ______________________

______________________ Age ______________________

Primary Physician ______________________ Sex ______________________

MD Phone #/Add. ______________________ Phone #(s) ______________________

Allergies ______________________________

Current Medication(s) ______________________________

____

____

HT ____________ WT ____________ BP ____________ BMI ____________

PERSONAL DATA

1. *Have you or any blood relative ever had any of the following conditions?*

CONDITION	YES	NO	WHEN	PATIENT	BLOOD RELATIVE
Arthritis					
Asthma					
Bone Disease					
Cancer/Site					
Cholesterol					
Depression					
Diabetes/Type					
Glaucoma					
Gout					
Heart Disease *(describe)*					
High BP					
Kidney Problems *(describe)*					
Liver Problems *(describe)*					
Lung Problems					
Migraine					
Psychiatric Problems *(describe)*					
Seizures					
Thyroid Problems					
Ulcer					
Other					

PATIENT HISTORY (PAGE 2)

2. Have you ever had surgery? _____ Yes _____ No
   Type and Date: ____
   ____
   ____
   ____
3. Do you smoke cigarettes/cigar/chew? _____ Yes _____ No
   If yes, Amt: ______________________________ Day/Week/Month (circle one)
4. Did you ever smoke? _____ Yes _____ No When did you quit? _______
   How long did you smoke? _________
5. Do you drink beer, distilled spirits or wine? _____ Yes _____ No
   If yes, Amt: __________________ Week/Month/Year (circle one)
6. Female: Are you pregnant? _____ Yes _____ No Could you possibly be pregnant?
   _____ Yes _____ No Are you Breast-Feeding? _____ Yes _____ No
7. Have you ever been on a diet program before? _____ Yes _____ No
   What program? ____________________ When: __________________
   Were medications prescribed? _____ Yes _____ No
   If yes, what medications? ____________________________________
8. Are you currently taking any Over-The-Counter diet medication, and if so, what? ______
   ____
9. Have you Gained/Lost more than 15lbs. in the last year? _____ Yes _____ No
   If yes, how many lbs _____________ Gained _____________Lost
10. How did you hear about the program? ____________________________________
11. Do you take Over-The-Counter medications? _____ Yes _____ No
   If yes, please complete the following:

CONDITIONS	MEDICATION	HOW OFTEN
Allergies		
Colds		
Headaches		
Insomnia		
Pain(where?)		
Other		

Patient Signature: ____

Staff Signature: ____