Doctors Best
Weight Loss & Wellness Center
HEALTH • STAMINA • LONGEVITY

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(954) 252-5454
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Name:_____

Todays Date:_____/_____/_____

NEW PATIENT HISTORY FORM (F)

PLEASE LIST YOUR PRIMARY CARE PHYSICIAN

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

LIST ANY OTHER PHYSICIANS YOU SEE

NAME	SPECIALTY	CITY, STATE	DATE LAST SEEN

WHY ARE YOU SEEING US TODAY?_____

_____

_____

MEDICAL HISTORY HAVE YOU OR MEMBERS OF YOUR FAMILY HAD ANY OF THE FOLLOWING:

CONDTIONS	YOU	FAMILY
HIGH CHOLESTEROL		
HEART DISEASE/ ATTACK		
RHEMEUMATIC FEVER		
HIGH BLOOD PRESSURE		
STROKE		
BLOOD CLOTS		
ASTHMA		
TUBERCULOSIS		
DIABETES		
THYROID PROBLEMS		
LIVER DISEASE		
HEPATITIS		
GALLSTONES		

CONDTIONS	YOU	FAMILY
ARTHRITIS		
HIV/AIDS		
KIDNEY/ BLADDER PROBLEMS		
ANEMIA		
BLOOD TRANSFUSION		
BLEEDING DISORDER		
PROSTATE DISEASE		
PROSTATE CANCER		
ERECTILE DYSFUNCTION		
COLON CANCER		
BIRTH DEFECTS		
GENETIC/INHERITED		

OTHER MEDICAL HISTORY_____

_____

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PREVIOUS SURGERIES

YEAR	OPERATION	HOSPTIAL	COMMENTS

CURRENT PRESCRIPTION MEDICATIONS

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

CURRENT NON-PRESCRIPTION MEDICATIONS (INCLUDING HERBALS & SUPPLEMENTS)

NAME	DOSAGE	TIMES PER DAY	HOW LONG?

MEDICAL ALLERGIES

NAME	REACTION

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INSTRUCTIONS: Please note the symptoms in the list that you experience on a regular basis. Place an "X" in the column corresponding the frequency and severity of each symptom.

If you rarely have the symptom, just leave that line blank.

Symptom Frequency
1= A few days a Month
2= A few days a Week
3= Almost Every Day

Symptom Severity
1= Mildly Noticeable
2= More Bothersome
3= Severe/Debilitating

SYMPTOM						
Aches & Pains						
Fatigue (All-Day)						
Fatigue (Morning)						
Fatigue (Afternoon)						
Fatigue (Evening)						
Irritability						
Mood Swings						
Foggy Mind						
Anxiety						
Can't Fall Asleep						
Interrupted Sleep						
Waking Up Refreshed						
Carb. Cravings						
Depression						
Heavy Periods						
Cuclic PMS Symptoms						
Breakthrough Bleeding						
Hot Flashes						
Breast Tenderness						
Headaches						
Bloating						
Night Sweats						
Low Sex Drive						
Weight Gain	**Just Check "Severity" for each of these Symptoms**					
Hair Loss						
Dry, Thinning Skin						
Cold Body Temperature						
Vaginal Dryness						

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LIFESTYLE QUESTIONS:

Do you smoke cigarettes? _____ YES _____ NO If so, how many cigarettes per day? _____

Do you drink alcohol? _____ YES _____ NO If so, how many drinks per week? _____

Do you use street drugs? _____ YES _____ NO (All answers are confidential)

How many caffine-containing drinks do you have a say?_____ (Coffee, Tea, Sodas, Energy Drinks)

What time do you go to bed at night? _____ How long until you fall asleep? _____

What do you do when you wake up at night?_____

What time do you wake up at on a typical work day?_____

Do you take anything to help you sleep?_____

Do you eat after 8pm? _____ YES _____ NO Do you feel refreshed when you wake up?_____

Do you exercise at least 30 minutes at a time, at least 3 days per week? _____ YES _____ NO

What do you do for exercise?_____

What time of the day do you usually exercise?_____

How many meals a day do you eat?_____ Do you snack between meals?_____YES _____NO

Do you drink at least 64 ounces of water per day? _____YES _____NO

What prescription diet pills have you taken in the past?_____

What was your most successful diet?_____ How much did you lose?_____

How much weight would you realistically like to lose in the next year? _____ Pounds

STRESS QUESTIONS

**Please circle all current stressors in your life.*

MOVED YOUR HOME	JOB CHANGE	JOB STRESS/LOSS
ILL FAMILY MEMBERS	MARITAL PROBLEMS	DIVORCE/SEPARATION
DEATH OF SPOUSE/CHILD	FORCLOSURE/BANKRUPTCY	LEGAL PROBLEMS
NEW MARRIAGE	RETIREMENT	TROUBLE WITH IN-LAWS
PROBLEMS WITH CHILDREN	NEW PERSON LIVING WITH YOU	

THANK YOU THIS CONCLUDES YOUR QUESTIONNAIRE

NAME:_____ ***DATE:***_____