ROPER
ST. FRANCIS

CLINICAL HISTORY FORM

Name: _____

Date: _____

Date of Birth: _____

Age Today: _____

Primary Care Physician: _____

WEIGHT HISTORY

Height:_____ Weight_____

Age of obesity onset:

☐ 0-2 years old ☐ 2-12 years old ☐ 12-18 years old ☐ Young adult ☐ Middle Age ☐ Pregnancy

How many years have you been at your present weight? _____

Greatest single weight loss: _____

How did you lose this weight? _____

How long was it maintained? _____

Do you exercise regularly? _____

What activities? _____

Were there any significant events that lead to the weight gain?

☐ Loss of a loved one
☐ Trauma, accident or illness
☐ Loss of employment
☐ Other:_____

Bring in your most recent labs from your primary care physician. A recent cholesterol panel and glucose level would be most informative. If your labs have not been checked in a while, inquire about having them checked before our first visit.

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PHYSICAL HISTORY

Have you been diagnosed with or have you ever experienced any of the following conditions?

Y	N	Endocrinology
☐	☐	Type I Diabetes (Insulin dependant)
☐	☐	Type II Diabetes (Non-Insulin dependant)
☐	☐	Hyperthyroid
☐	☐	Hypothyroid
☐	☐	Goiter
☐	☐	Grave's Disease
		Neurological
☐	☐	Numbness or tingling in the hands or feet
☐	☐	Seizures
☐	☐	Epilepsy
☐	☐	Multiple Sclerosis (MS)
		Skin
☐	☐	Dermatitis
☐	☐	Rashes
☐	☐	Open sores
☐	☐	Psoriasis
		Hematology
☐	☐	Blood clots from an injury or accident
☐	☐	Anemia
☐	☐	DVT (Deep Vein Thrombosis/Active Thrombophlebitis in legs)
☐	☐	Thrombocytopenia – low platelets; bleeding problems
☐	☐	Heparin exposure
☐	☐	Coumadin use
☐	☐	Iron supplements
☐	☐	Hemophilia
		OB/GYN
☐	☐	Hormone replacement
☐	☐	Birth Control Pill/Patch
☐	☐	Irregular periods
☐	☐	Difficulty in conceiving
☐	☐	Excessively painful periods

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Y	N	Gastrointestinal
☐	☐	GERD
☐	☐	Heartburn
☐	☐	Stomach (peptic ulcer)
☐	☐	Duodenal ulcer
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Vomiting
☐	☐	Colitis
☐	☐	Irritable Bowel Syndrome
☐	☐	Crohn's Disease

Gallbladder Disease

☐	☐	Gallstones (Cholelithiasis)
		Are you symptomatic? _____
☐	☐	Inflammation/infection of gallbladder (Cholecystitis)

Respiratory

☐	☐	Asthma
☐	☐	Chronic Bronchitis
☐	☐	Sleep Apnea
☐	☐	Sleep Apnea treated C-Pap/Bi-Pap
☐	☐	Shortness of breath on exertion
☐	☐	COPD (Chronic Obstructive Pulmonary Disease)
☐	☐	Emphysema

Cardiovascular

☐	☐	Heart Attack (Myocardial Infarction)
☐	☐	Angina
☐	☐	Palpitations
☐	☐	High Blood Pressure (Hypertension)
☐	☐	Stroke (CVS)
☐	☐	Mini-Stroke (TIA)
☐	☐	Chest Pain
☐	☐	Heaviness in chest
☐	☐	Congestive heart failure
☐	☐	Peripheral vascular disease
☐	☐	High cholesterol

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Y	N	Infectious Disease
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	HIV Positive
☐	☐	Liver Disease

		Genital-Urinary
☐	☐	Recurrent urinary infection
☐	☐	Kidney stones
☐	☐	Kidney disease
☐	☐	Renal/Kidney failure (dialysis)
☐	☐	Gout
☐	☐	Stress incontinence

		Musculoskeletal
☐	☐	Arthritis
☐	☐	Back pain
☐	☐	Migraine headaches (describe): _____
☐	☐	Pain in weight bearing joints

		Psychological
☐	☐	Depression: Medication: _____
☐	☐	Bi-Polar Disorder
☐	☐	Anxiety
☐	☐	Suicide attempt
☐	☐	Anorexia
☐	☐	Bulimia

		Cancer
☐	☐	Lung
☐	☐	Breast
☐	☐	Prostate
☐	☐	Colon
☐	☐	Lymphoma
☐	☐	Other:_____

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Provide any pertinent information which you feel will help the doctor in treating you.

Medications:

Bring your medications with you to your first visit.

List all prescription medications taken currently on a regular basis:

Do you take aspirin on a regular basis? ☐ Yes ☐ No

Brand _____ Dosage _____

Medication	Dosage	Frequency	Date Started	Reason for taking	Ordering Physician

Are any of the above medications taken for hormone replacement or birth control? ☐ Yes ☐ No

PAST SURGICAL HISTORY:

Operation/Procedure	Reason	Date	Hospital

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PRIOR SURGICAL PROBLEMS:

Describe all problems	Date	Hospital
Anesthesia:		
Wound:		
Bleeding:		
Clotting:		
Fever:		
Other:		

SIGNIFICANT FAMILY HISTORY:

Check any family member who has suffered or experienced any of the following conditions
M=Maternal P=Paternal

					Grandmother		Grandfather		Aunt(s)		Uncle(s)	
	Mother	Father	Sister(s)	Brother(s)	M	P	M	P	M	P	M	P
Hypertension												
Diabetes												
Arthritis												
Cardiac disease												
Stroke												
Lung disease												
Cancer												
Obesity												
Liver disease												
Early death												
DVT blood clots												

PAST MAJOR MEDICAL HISTORY:

Major Illness	Date	Treatment	Physician

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GENERAL HISTORY:

Do you smoke? ☐ Yes ☐ No

Frequency/Amount per day and # of years: _____

Do you drink alcohol? ☐ Yes ☐ No

Frequency/Amount:_____

Check if you use any of the following? ☐ Wheelchair ☐ Walker ☐ Oxygen

Do you use any drugs (non-prescription/over the counter/illicit? ☐ Yes ☐ No

Drug	Frequency

ALLERGIES:

Are you allergic to any medication: ☐ Yes ☐ No

Medication	Reaction

Are you allergic to any foods? (dairy, wheat products, shellfish) ☐ Yes ☐ No

List:

Are you allergic to any materials? (latex, surgical tape, iodine) ☐ Yes ☐ No

List:

What was the date of your last physical examination? _____

Significant findings:

_____

_____

_____

_____