Commonwealth Weight Loss Center

PATIENT MEDICAL INFORMATION

Patient Name: _____Age: _____ Date of Birth: ____/____/____ Date: ____/____/____

What problem brought you here? _____

How long have you had it? _____

Please list previous surgeries with dates: _____

Do you have or have you had any of the following? (Please check "Yes" or "No")

PROBLEM	Yes	No	PROBLEM	Yes	No
Have you had a heart attack or cardiac arrest			Migraine		
High Blood Pressure			Hemorrhoids		
Diabetes			Hernia (location)		
Cancer (what type?)			Kidney disorder		
Elevated Cholesterol			Bladder disorder		
Arthritis			Prostate disorder		
Eye, ear, nose, mouth, or throat disorder			Seizures, convulsions, strokes		
Skin problems			Psychiatric conditions		
Recent dental problem			Other neurological disorder		
Respiratory disorder			Sciatica, back pain		
Heart problem or murmur			Circulation problem		
Liver, pancreas or gallbladder			Aneurysm		
Ulcer or other stomach disorder			Phlebitis, blood clots		
Hepatitis A, B. or C			Fever, night sweats, weight loss		
Diverticulitis, colitis			Anemia		
Other intestinal disorder			Bleeding tendency		
HIV			History of blood transfusion		
Thyroid/endocrine			Other medical problems not noted above		
Do you have a pacemaker or defibrillator implanted			Do you have any other artificial graft or implant		

HEALTH RELATED QUESTIONS	Yes	No	DAILY USAGE
Do you pre-medicate before dental procedures (*example: antibiotics)*			
Do you use tobacco □ Smoke □ Chew			If yes, how much per day?
If you have ever smoked please write start & end dates and # packs per day.			
Do you use alcohol			If yes, how much per day?

Please list for your family medical history, after each relative, any important medical conditions like heart disease, stroke, cancer, etc.

Mother:

Father:

Sisters:

Brothers: