DOS:
Scanned to PF Chart: ☐ Yes ☐ No
Staff Initial:

KEVIN M. HOGAN, D.C.
CLINIC DIRECTOR

R. BLAKE SAYRE, M.D.
MEDICAL DIRECTOR

DEBRA HEMPHILL, ARNP

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*	**Phone number:**
Address:	**City/State/Zip:**
Sex: ☐ Male ☐ Female	**DOB:**
Primary Care Physician:	**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

HEALTH HABITS AND WEIGHT HISTORY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.					
Exercise	☐ Sedentary (No exercise)				
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)				
Diet	Are you dieting?			☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?			☐ Yes	☐ No
	# of meals you eat in an average day?				
	Rank salt intake	☐ Hi	☐ Med	☐ Low	☐ None
	Rank fat intake	☐ Hi	☐ Med	☐ Low	☐ None
	Caffeine intake	☐ Coffee	☐ Tea	☐ Cola	☐ None
	Number of cups per day	☐ 1-2	☐ 2-3	☐ 3 or more	☐ None
	What foods do you crave?				
	What diets have you tried?				
Weight History	What type of weight were you as a child:				
	☐ Thin	☐ Average	☐ Heavy	☐ Obese	
	When did you start gaining weight?				
	What was your highest weight?		What was your lowest weight?		
	Are you committed to losing weight?			☐ Yes	☐ No
	What barriers prevent you from losing weight?				
	What weight do you desire to be?				
	Do you believe the above desired weight is realistic?			☐ Yes	☐ No

ALCOHOL CONSUMPTION

Do you drink alcohol?				☐ Yes	☐ No
If yes, what kind?	☐ Beer	☐ Liquor	☐ Wine	☐ Other	
How many drinks per week?	☐ 1-3	☐ 3-5	☐ 5 or more	☐ None	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father ☐ **Alive** ☐ **Deceased**			**Children**	☐ M ☐ F	
Mother ☐ **Alive** ☐ **Deceased**				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

FOR OFFICE USE ONLY:

Height	
Weight	
BMI	
HR	
BP	
B-12 Lipo B-12	R glut L glut R delt L delt

CURRENT MEDICATIONS

Medication (Brand or Generic Name)	Dose	How much/How Often Do You Take The Medication	Reason	Date Started	Prescriber

ALLERGIES TO MEDICATIONS

Name of medication	Reaction you Had

Past Medical History

Please circle yes or no

CARDIOVASCULAR		
Cardiac Pacemaker	Yes	No
High Blood Pressure	Yes	No
Abnormal ECG/EKG	Yes	No
Angina Pectoris/Chest Pain	Yes	No
Coronary Artery Disease Heart Attack	Yes	No
Heart Failure	Yes	No
Heart Murmur	Yes	No
Irregular Heart Beat	Yes	No
Atrial Fibrillation	Yes	No
Peripheral Vascular Disease	Yes	No
Elevated Cholesterol/Lipids/Triglycerides	Yes	No
Rheumatic Fever	Yes	No
Stroke	Yes	No
Valvular Heart Disease	Yes	No
Other Heart Disease If yes, define here:		

RESPIRATORY		
Asthma	Yes	No
Emphysema	Yes	No
Bronchitis	Yes	No
Sleep Apnea	Yes	No
Pneumonia	Yes	No
Chronic Sinusitis	Yes	No
Wheezing	Yes	No
Shortness of Breath	Yes	No
Lung Cancer	Yes	No
Tuberculosis	Yes	No
Pulmonary Embolus	Yes	No
Other Lung Disease If yes, define here:		

HEMATOLOGIC		
Anemia	Yes	No
Bleeding Disorders	Yes	No
Clotting Disorders	Yes	No
Deep Venous Thrombosis	Yes	No
Hyperuricemia	Yes	No
Leukemia	Yes	No
Lymphoma	Yes	No
Other Blood Disorders If yes, define here:		

ENDOCRINE		
Type 1 Diabetes	Yes	No
Type 2 Diabetes	Yes	No
Insulin Resistance	Yes	No
Hyperthyroidism	Yes	No
Hypothyroidism	Yes	No
Other Thyroid Disorder	Yes	No
Parathyroid Disorder	Yes	No
Binge Eating Disorder	Yes	No
Weight Gain	Yes	No
Weight Loss	Yes	No
Bulimia	Yes	No
Anorexia	Yes	No
Metabolic Syndrome	Yes	No
Polycystic Ovarian Syndrome (PCOS)	Yes	No
Other Endocrine Disease If yes, define here:		

GASTROINTESTINAL		
GERD (Reflux)	Yes	No
Peptic Ulcer Disease	Yes	No
Stomach Pain	Yes	No
Food Sensitivity	Yes	No
Liver Disease	Yes	No
Hepatitis Cirrhosis	Yes	No
Gallstones	Yes	No
Pancreatitis	Yes	No
Inflammatory Bowel Disease	Yes	No
Irritable Bowel Syndrome	Yes	No
Ulcerative Colitis	Yes	No
Crohn's Disease	Yes	No
Celiac Disease	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Diverticulosis	Yes	No
Other GI Disease If yes, define here:		

NEUROLOGICAL		
Stroke	Yes	No
Seizure Disorder	Yes	No
Parkinson's Disease	Yes	No
Multiple Sclerosis	Yes	No
Bell's Palsy	Yes	No
ADD/ADHD Anxiety	Yes	No
Bipolar Disorder	Yes	No
Dementia	Yes	No
Cognitive Impairment	Yes	No
Chronic Headaches	Yes	No
Migraines	Yes	No
Depression	Yes	No
Autism	Yes	No
Schizophrenia	Yes	No
Other Neurologic Disorders If yes, define here:		

MUSCULOSKELETAL		
Arthritis	Yes	No
Back Pain	Yes	No
Chronic Pain	Yes	No
Degenerative Disc Disease	Yes	No
Joint Pain	Yes	No
Fibromyalgia	Yes	No
Muscle Pain	Yes	No
Gout	Yes	No
Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Other Musculoskeletal Disease If yes, define here:		

Informed Consent for Medically Directed Weight Loss

Florida Rule 64B8-9.012 *Standards for the Prescription of Obesity Drugs* requires that upon the initiation of Medically Directed Weight Loss programs, which may include the prescription of medications to enhance weight loss that the following information be provided to constitute informed consent.

1. There is a lack of scientific data regarding the potential danger regarding the long term use of combination weight loss treatments. More specifically, the appetite suppressant you will be prescribed is approved for short term use for patients with a BMI greater than 30, or a BMI greater than 27 in the presence of one or more medical conditions related to obesity.
2. The weight loss program that will be prescribed is a multimodal program which includes dietary intervention, physical exercise, and when appropriate the prescription of appetite suppressants.
3. As with all medical interventions there are risks and benefits. The risks include adverse reactions to any medications prescribed. Benefits of treating obesity include reducing complications from high blood pressure, heart disease, diabetes, and musculoskeletal problems.

Patient Name_____ Date_____

Patient Signature_____

EAST HILL
MEDICAL GROUP

FOR OFFICE USE ONLY

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Blood Pressure: _____ HR:_____

Are the following normal?

Area	Yes	No	Comments
Appearance			
Skin			
Head			
Eyes			
Ears			
Nose			
Mouth/Throat/Teeth/Gums			
Nodes			
Heart			
Lungs			
Abdomen			
Extremities			
Spine			
Neuro			
Other			

Treatment Notes:

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