InShapeMD

Patient Medical History Form

Patient Name: (Last)_____(First)_____(MI)___

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____Cellular: _____

Email: _____

Birth date: _____Age: _____ Sex: M F

In Case of Emergency:

Name: _____Relationship: _____ Phone: _____

Family Physician: _____ Phone: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
   Explain a "no" answer:

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?

3. Are you taking any medications at the present time? Yes No

Prescription Drugs: List all

	Drug:	Dosage:
1.		
2.		
3.		
4.		
5.		

Over-the-Counter medications, vitamins, supplements: List all Yes No

	Product	Dosage
1.		
2.		
3.		
4.		
5.		

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ Heart Attack /Heart Disease
_____ Diabetes	_____ Hypertension	_____ Other: _____

11. Serious Injuries: (Only if it effects ability to exercise) Yes No
    Specify (list all) Date

12. Any Surgery: (Major Surgeries Only) Yes No
    Specify: (List all) Date

13. History of Sleep Apnea: Yes No

14. Any allergies to any medications? Yes No

Please list: _____

_____

_____

15. Family History: (As it relates to Obesity)

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

_____ _____
Patient's Signature Date

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	Testosterone Therapy Questionnaire for Women	YES	NO
1	Do you experience hot flashes?		
2	Do you have night sweats?		
3	Do you frequently feel stressed, anxious, or nervous?		
4	Have you recently gained weight (in the abdomen, hips, buttocks, or thighs)?		
5	Do you have trouble sleeping?		
6	Do you find it harder to remember things?		
7	Are you currently feeling depressed?		
8	Have you noticed a loss in your sexual interest?		
9	Do you feel irritable, impatient, or angry without control over your emotions?		
10	Do you have urinary leakage when you cough or sneeze?		

About your score: Scoring high (answering 'yes' to 3 or more questions) indicates that you are suffering from significant symptoms as a result of hormone deficiency.

Through comprehensive lab testing, we can create a customized plan that includes bio-identical hormone therapy if necessary, along with an individualized fitness and nutrition regimen to help you restore your hormones levels and get you on your way to live better, longer.

Name: _____ DOB: _____ Date: _____

Height: _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

_____ Date: _____
Reviewed by medical practitioner

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Name: _____ **Date:** _____

Have you ever been involved in a structured weight loss program?	Y	N
If "Yes" (*above*), was the program medically-based and overseen by a physician?	Y	N
Did you attain the results you were seeking?	Y	N
Were you committed to your program?	Y	N
Is your job sedentary?	Y	N
Are you married or involved in a relationship?	Y	N
Do you have any Children	Y	N
Does your significant other also want to lose weight?	Y	N
Does your significant other support your involvement in a weight loss program?	Y	N
Do you have any friends or relatives that are currently attending InShapeMD?	Y	N

Are there any Special Events or Occasions you would like to get ready for?

_____

How long have you been thinking about being on a weight loss program? _____

How would you rate your eating habits on a scale from 1-10? (*10 = best*) _____

What type of recreational activities do you and your family enjoy? _____

_____

Do you exercise currently? _____

_____

_____

What is your weight loss goal? (*Please identify how many pounds you want to lose*) _____

On a scale from 1-10, how committed are you in achieving your weight loss goal? (*10 = extremely committed*) _____

What has been your biggest challenge in starting, sticking with, and completing a weight loss program? _____

_____

more

How did you hear about InShapeMD? _____

Do you think any of the following will help you reach your weight loss goal? (*Please check the boxes*)

- ☐ An environment where I am empowered by other people who share the same goals.
- ☐ A customized, family-friendly meal plan which allows me the flexibility to eat out.
- ☐ Seeing a positive change in my body every 3-4 weeks.
- ☐ A program that allows me to involve my family and friends.
- ☐ Educational workshops about weight loss, wellness and nutrition.
- ☐ A program where I can reach my goals in just one 30-minute session a week!