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

InShapeMD.

	Testosterone Therapy Questionnaire for Men	YES	NO
1	Do you have a decrease in Libido (sex drive)?		
2	Do you have a lack of energy?		
3	Do you have decrease in strength and/or endurance?		
4	Have you lost height?		
5	Have you noticed a decreased "enjoyment of life"?		
6	Do you have mood swings?		
7	Are your erections less strong?		
8	Have you noticed a recent deterioration in your ability to play sports?		
9	Do you tire easily?		
10	Have you had a recent deterioration in your work performance?		
11	Do you have sleep apnea?		
12	Have you noticed a loss of muscle mass?		

If you have answered “yes” to questions 1 or 7, or any 3 other questions, you may be experiencing androgen deficiency (low testosterone level).

Name: _____ DOB: _____ Date: _____

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

_____ Date: _____

Reviewed by medical practitioner

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!