CROUCH CLINIC **PATIENT MEDICAL HISTORY and REVIEW OF SYSTEMS**

Name: _____ Date of Birth: _____ Sex: M F **Today's Date:** _____

Primary Care Physician: _____ Physician's Phone: _____

Physician Address:

DRUG ALLERGIES	General	Head/Ears/Nose/Throat	Pulmonary	
List all **DRUG Allergies:**	Weight Gain	Glaucoma	Asthma	Insomnia
_____	Dry Skin/Thin Hair	Glasses/Contacts	Cough	Waking in the Night
_____	Feel Cold	Cataract/Visual Problems	Wheezing	Never Feel Rested
_____	Body Aches	Hearing Problems	Shortness of Breath	Snoring
_____	Low Sex Drive	Sore Throat	Emphysema/COPD	Sleep Apnea
_____	Brain Fog/Forgetful	Food Allergy/Sensitivity	Positive TB Test	Use of CPAP
_____	Fatigue/Low Energy	Seasonal/Other Allergies		Previous Sleep Study

Cardiac	Gastrointestinal		Genitourinary	Metabolic
Chest Pain with Exertion	Abdominal Pain	Diarrhea	Blood in Urine	High Blood Pressure
Chest Pressure	Trouble Swallowing	Constipation	Hesitancy	Diabetes
Heart Failure	Nausea/ Vomiting	Bright Red Blood in Stool	Kidney Stones	High Cholesterol
Palpitations/Irregular Beat	Yellow Jaundice	Hemorrhoids	Frequent Urination	Thyroid Problems
Murmur/Rheumatic Fever	Black/Tarry Stool	Stomach Ulcers	Pain on Urination	Anemia
Coronary Artery Disease	Fatty Liver/Liver Disease	Heartburn or Acid Reflux	Prostate Problems	Cancer_____
Heart Attack	Colonoscopy	Gallbladder Disease	Freq.Urinary Infection	Other

Hematological	Neurological	Musculoskeletal	Psychological	Gynecological
Abnormal Bleeding	Neurologic Disease	Joint Pain	Depression	**FIRST DATE OF LAST PERIOD**_____
Easy Bruising	Chronic Headaches	Swelling Extremities	Anxiety	Breast Pain/Lumps
Blood Clots in Legs/Lungs	Migraines	Back Pain	Stress	Hot Flashes
HIV/AIDS	Dizziness	Leg Pain/Cramps	Emotional Eating	Menopause
Nose Bleeds	Passing Out	Leg Ulcers	Ever received psychiatric	Hysterectomy
Hepatitis B or C	Seizure/Epilepsy	Varicose Veins	treatment or counseling	Irregular Cycle
Leukemia	Stroke	Broken Bones		

Weight History: Current weight_____ Weight one year ago_____ Goal Weight_____ Usual Healthy weight_____

Weight at age 20_____ Highest **NON-PREGNANT** weight_____ How tall are you? _____ feet _____ inches

What is the **main reason** you want to lose weight? _____

What is the **main cause** of your weight gain? _____

LIST ALL **SURGERIES/DATES**	CURRENT **MEDS/VITAMINS/DOSAGE**	**OTHER HISTORY, WEIGHT LOSS ATTEMPTS,MEDICATIONS,DIETS**	**DATE OF LAST:**	**RESULTS NORMAL?**
_____	_____	_____	**MAMMOGRAM**_____	**YES NO**
_____	_____	_____	**BREAST EXAM**_____	**YES NO**
_____	_____	_____	**PAP SMEAR**_____	**YES NO**
_____	_____	_____	**PROSTATE EXAM**_____	**YES NO**
_____	_____	_____	**PSA TEST**_____	**YES NO**

Have you ever had any type of **eating disorder? Y/N** (*Please circle)* anorexia/bulimia/laxative abuse

Do you **exercise?** _____ What Kind? _____ How Much? _____

Do you eat breakfast?__ lunch?__ dinner?__ at night? __ when stressed? ___

Do you: **SMOKE? Y/N**____packs/day x ___years; **use CAFFEINE? Y/N**_____drinks/day;

Do you: Use **STREET DRUGS? Y/N** _____ **drink ALCOHOL? Y/N**____drinks/week

Are you: ___ married ___single ___divorced ___separated. Number of **children**_____ Ages_____

Family Medical History: (*Please circle)* Has any blood relative ever had Heart Disease, Diabetes, Thyroid Disease, Liver Disease, Kidney Disease, High Blood Pressure, Stroke, Glaucoma, Arthritis, Obesity, Cancer or Psychiatric Disorder?

	Age	**Health**	**Medical Problems**	**Cause of Death**	**Overweight?**
Father:					
Mother:					
Brothers:					
Sisters:					
Other Relatives:					

Patient Signature_____ Physician/PA Signature_____

Your signature indicates the above information is complete and true. Physician/PA will sign after reviewing with patient. 030816