PICR
Weight Management Center

HISTORY AND PHYSICAL

Please individually Check Each One:

Please check if you currently have or have ever had any of the medical conditions listed below.

	Present	Past		Present	Past	
Acid Reflux						High Blood Pressure
Anemia (low blood count)						High Cholesterol
Anxiety						Hip Problems
Arthritis						HIV/AIDS
Asthma						Irritable Bowel Syndrome
Back problems						Jaundice
Bipolar						Kidney Disease
Bleeding Tendency						Knee Problems
Blood Disease						Leg Problems
Cancer						Migraine Headaches
Carpal Tunnel Syndrome						Multiple Sclerosis
Chemical Dependency						Osteoarthritis
Chemotherapy						Osteoporosis
Chronic Fatigue Syndrome						Pacemaker
Circulatory Problem						Pneumonia
Congenital Heart Lesion						Polycystic Ovarian (PCOS/PCOD)
COPD						Prostate Problem
Cough						Psychiatric Care
Depression						Respiratory Disease
Diabetes						Rheumatic Fever
Emphysema						Scarlet Fever
Epilepsy						Sinus Trouble
Foot problems						Sleep Apnea
Fibromyalgia						Stress
Glaucoma						Stroke
Gout						Thyroid Problem
Heart Disease						Tuberculosis
Heart Murmur						Ulcer
Hepatitis Type_____						Urinary Tract Infection
Hernia (non-groin)						Venereal Disease
Herpes						

*Please list and describe any other medical conditions not listed above:

_____

_____

*Please list past surgeries and hospitalizations:

_____

_____

_____

Medication

Please list all medications you currently take that are prescribed by a physician or purchased over the counter. This includes pain relievers, aspirin, eye drops, creams, birth control pills/patches/inserts, hormones, antacids, vitamins, minerals and other health food supplements.

Name of Medication	Why was the medication prescribed?	Dosage	How often?	Date Started
Example: Advil	**Joint Pain**	**Two 400 mg tablets**	**3 times/day**	**2-21-2000**

Allergies to medication?

Please list_____

Weight Loss History

At what age did you start gaining excessive weight? _____ Is your weight now stable? Y N Current Weight: _____
How much weight do you want to lose? _____ How much time do you expect it to take to get to your goal weight? _____
Are you aware of any medical reasons for the weight gain? _____ Are you continuing to gain weight? Y N
What do you think will be the benefits of losing weight? _____
What is your main motivation to lose weight at this time? _____
Have you ever had any weight loss surgery (liposuction, gastric banding/stapling, intestinal bypass, etc.)? Y N
If so, describe: _____

Exercise

Do you exercise and if so, how often do you exercise?

- ☐ Never
- ☐ Rarely
- ☐ Once a week
- ☐ Daily
- ☐ 2-3 times a week
- ☐ 4-5 times a week

What type of exercise do you do?

_____

Alcohol/Drug/Tobacco Use:

Do you drink alcohol? Y/N More than 2/day? Y N If so, how many? _____
Do you use drugs? Y/N What type? _____ How often? _____
Do you smoke? Y/N Do you plan to stop while on the program? Y/N
Have you ever been treated for alcohol/drug dependency? Y/N When? _____

Women Only:

Are you pregnant? Y/ N Are you trying to get pregnant? Y/ N Date of Last Menstrual Period: _____
Taking birth control? Y/ N If yes, type? _____ Patient Initials: _____

Your Mental Health History:

Have you ever had symptoms of or been diagnosed with any of the following illnesses?

Anorexia Nervosa: Y N Unsure
Bulimia Nervosa: Y N Unsure
Binge-eating disorder: Y N Unsure
Other type of eating disorder: Y N Unsure If so, what type? _____
Learning disability: Y N Unsure
Personality disorder: Y N Unsure If so, what type? _____
Depression: Y N Unsure
Bipolar disorder (manic-depression): Y N Unsure
Anxiety disorder: Y N Unsure If so, what type? _____
Panic attacks: Y N Unsure
Phobia(s): Y N Unsure
Obsessive-compulsive disorder: Y N Unsure
Posttraumatic stress disorder: Y N Unsure
Schizophrenia or schizoaffective disreder: Y N Unsure
Alcohol dependence or abure: Y N Unsure
Drug dependence or abuse: Y N Unsure

Other type of emotional problems or mental illness? _____
Have you ever intentionally injured yourself? Y N If so, when and how? _____
Have you ever tried to kill yourself? Y N If so, when and how? _____
Have you ever intentionally injured someone else? Y N If so, when and how? _____

Mental Health Treatment

Are you currently seeing a therapist? Y N
If YES, please list this provider's name
Name: _____

Address: _____

Telephone #: _____