

Medical History Form

IT IS CRUCIAL THAT YOU COMPLETE THIS FORM BEFORE YOUR FIRST VISIT AND MAIL/FAX/BRING IT TO US IN ADVANCE OF YOUR APPOINTMENT. WITHOUT IT YOUR INITIAL VISIT MAY NEED TO BE RESCHEDULED!

Name: _____ Date of birth _____ Age: _____ Sex: M F

Family Physician: _____ Phone: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
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
What: _____ Dosages: _____
What: _____ Dosages: _____
4. Any allergies to any medications? Yes No
If yes, please list medications and effects (i.e. hives, shortness of breath, etc.)

5. History of High Blood Pressure? Yes No
6. History of Diabetes? Yes No
At what age were you diagnosed? _____
7. History of Heart Attack or Chest Pain? Yes No
History of shortness of breath? Yes No
8. History of Swelling Feet? Yes No
9. History of Frequent Headaches? Yes No
Migraines? Yes No
Dizziness? Yes No
Fatigue? Yes No
10. History of Constipation (difficulty in bowel movements)? Yes No
11. History of Glaucoma? Yes No
12. Gynecologic History:
Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual: Age at Onset: _____ Numbers of menses per year _____
Duration: _____ days

Are they regular: Yes No
 Pain associated: Yes No
 Last menstrual period: _____
 Hormone Replacement Therapy: _____ Yes No
 What: _____
 Birth Control Pills: _____ Yes No
 Type: _____
 Last Check Up: _____
 Abnormal hair growth Yes No
 Hair loss Yes No
 Recent changes in sexual drive Yes No

13. Serious Injuries: Yes No
 Specify: _____ Date: _____

14. Any Surgery: Yes No
 Specify: _____ Date: _____
 Specify: _____ Date: _____

15. Family History:

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

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____
 Asthma: Yes No Who: _____
 Epilepsy: Yes No Who: _____
 High Blood Pressure Yes No Who: _____
 Kidney Disease: Yes No Who: _____
 Diabetes: Yes No Who: _____
 Tuberculosis: Yes No Who: _____
 Psychiatric Disorder Yes No Who: _____
 Heart Disease/Stroke Yes No Who: _____
 Alcoholism Yes No Who: _____

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/Joint Pain	_____ Osteoporosis	_____ Dry skin
_____ Depression	_____ Mood Swings	_____ Heartburn

____ Nausea/Vomiting
____ Hypoglycemia

____ Frequent colds/viruses
Other: _____

____ Increase in Skin Tags

Nutrition Evaluation:

1. Present Weight: _____ Height (no shoes): _____ Desired Weight: _____
 2. In what time frame would you like to be at your desired weight? _____
 3. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
 4. What is the main reason for your decision to lose weight? _____
 5. When did you begin gaining excess weight? (Give reasons, if known): _____

 6. What has been your maximum lifetime weight (non-pregnant) and when? _____
 7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

- What was the toughest hurdle for you during your last weight loss attempt? _____

- Have you found it difficult to lose weight even with exercise? Yes No
- What were some of the most important things that you learned during your last weight loss attempt?

8. Is your spouse, fiancée or partner overweight? Yes No N/A
 9. By how much is he or she overweight? _____
 10. How often do you eat out? _____
 11. What restaurants do you frequent? _____
 11. How often do you eat "fast foods?" _____
How often do you eat fresh fruits and vegetables? _____
 13. Who plans meals? _____ Cooks? _____ Shops? _____
 14. Do you use a shopping list? Yes No
 15. What time of day and on what day do you shop for groceries? _____
 16. Food allergies: _____

17. Food dislikes: _____

18. Food you crave: _____

Are you hungrier when you eat breakfast? []Yes []No
Do you find it difficult to stop eating starches and sweets once you start? []Yes []No

19. Any specific time of the day or month do you crave food? (i.e. close to period) _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No
What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Y N Hungrier when you eat starches and sugars? Y N

What do you do? _____
Do you awaken with a headache if you have eaten starches and/or "sweets" the day before? Y N

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

Do you eat because you are hungry or for comfort? _____

29. Smoking Habits: (answer only one)

- ___ You have never smoked cigarettes, cigars or a pipe.
- ___ You quit smoking ___ years ago and have not smoked since.
- ___ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
- ___ You smoke up to 20 cigarettes per day (1 pack).
- ___ You smoke 30 cigarettes per day (1-1/2 packs).
- ___ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast

Time eaten: _____
Where: _____
With whom: _____

Typical Lunch

Time eaten: _____
Where: _____
With whom: _____

Typical Dinner

Time eaten: _____
Where: _____
With whom: _____

31. Describe your usual energy level: _____

32. Activity Level: (answer only one)

- Inactive—no regular physical activity with a sit-down job.
- Light activity—no organized physical activity during leisure time.
- Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
- Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week
- Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: (answer only one)

- You are always calm and easygoing.
- You are usually calm and easygoing.
- You are sometimes calm with frequent impatience.
- You are seldom calm and persistently driving for advancement.
- You are never calm and have overwhelming ambition.
- You are hard driving and can never relax.

34. Do you have trouble sleeping Yes No

If yes, how long have you had trouble sleeping? _____

How often do you have trouble sleeping _____ nights per week

How does this affect you during the day? _____

Do you sleep restlessly? Yes No

Do you snore loudly? Yes No

35. Please describe your general health goals and improvements you wish to make: _____

This information will assist us in assessing your particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.

CONFIDENTIAL PATIENT INFORMATION

The following is needed in order to better serve you. Please complete all questions. If you need help, please ask the receptionist.

Today's date: _____

Name: _____ Home Phone: _____ Cell: _____

SS#: _____ Drivers License # _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Birthday: _____ Marital Status: _____ : S M W D No: of Children _____

Your Employer: _____ Occupation: _____ Years on the Job: _____

Employer Address: _____ City: _____ Zip: _____

Spouse's Name: _____ Age: _____ Birthday: _____

Spouse's Phone: _____ Cell: _____

Spouse Employed By: _____ Employer Address: _____

City: _____ State: _____ Zip: _____

Please Circle one Payment Type: Cash, Check , All Major Credit Cards Excepted.

Other Payment Plan Options: Care Credit Application (No Interest for 6 Mo.) Ask front desk for details.

Describe the Major Complaints that bring you to our office

Is your condition due to an accident? ___ Yes ___ No. date of Accident? _____

Type of Accident ? ___ Work/Job ___ Home ___ Auto ___ Other _____

Past Year? ___ Past 5 Years ___ Over 5 Years ___ Never _____

Signature: _____

PATIENT CONSENT TO LEAVE DETAILED MESSAGE/INFORMATION

Dear Patient:

Dr. Byers requires our staff to obtain prior authorization to leave voice mail/messages for the patient. This policy is to protect the patient and also to protect our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and a phone number on an answering machine asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Dr. Byers and/or staff to leave a message regarding treatment, test results or other necessary information.

1) On answering machine at home: _____

2) On voice mail at work: _____

3) On cell phone voice mail: _____

Please print phone number on lines

Patient's Signature

Date

I DO NOT consent to any messages being left on an answering machine other than caller's name and phone number.

Patient's Signature

Date

Thank You for choosing Dr. Byers as your
SottoPelle certified doctor.

Please give the nature or your referral:

Person _____

Other _____

Please understand that the pellets cannot
be removed after insertion.

Any questions please direct to Dr. Byers
during your consult.

Thank You Again,
Byers Wellness Center