Total Weight Loss Center

2790 Clay Edwards Dr., Ste. 600
North Kansas City, MO 64116

Health History

Patient Name: _____ **Date of Birth:** _____

CURRENT MEDICATIONS: (Include laxatives, herbal supplements and vitamins)

Name	Strength (e.g. mg dose)	Formulation (e.g. liquid, tablet, or capsule	Dose (i.e. how many, e.g. 1 tab)	Frequency (e.g. once daily)

Year of last Pneumovax: _____ **Year of Last Flu:** _____

Preferred/Pharmacy & Location: _____

LIST OF ALLERGIES (Please include type of reaction)

Are you allergic to **shellfish or iodine?** ☐YES ☐NO

Allergic to **Latex?** ☐YES ☐NO

Drug	Reaction

Total Weight Loss Center

2790 Clay Edwards Dr., Ste. 600
North Kansas City, MO 64116

Health History

Patient Name: _____ **Date of Birth:** _____

SOCIAL HISTORY:

Marital Status: (Check One): ☐Married ☐Single ☐Widowed ☐Divorced ☐Partner					
Your Occupation:				**How Long:**	
Do you use Tobacco now?	○ Yes ○ No	**Past?**	**Type/Amount?**	**How Long?**	
Do you drink alcohol now?	○ Yes ○ No	**Type?**	**Frequency**	**How Long?**	
Do you use chemical substances now? (check one)	○ Yes ○ No			**Past?**	○ Yes ○ No

Hobbies: _____

*** Please answer yes or no to whether you have experienced any of these symptoms within the past 6 months.**

Y	N	**Constitutional Symptoms**
☐	☐	Fatigue
☐	☐	Weight Loss
☐	☐	Fever
☐	☐	Chills
☐	☐	Night Sweats

Y	N	**Eye Symptoms**
☐	☐	Vision Problems
☐	☐	Blurry Vision
☐	☐	Seeing Double

Y	N	**Ear Symptoms**
☐	☐	Loss of Hearing
☐	☐	Ringing in Ears
☐	☐	Earache
☐	☐	Ear Discharge

Y	N	**Nose & Throat Symptoms**
☐	☐	Nasal Discharge
☐	☐	Nasal Congestion
☐	☐	Sinus Pressure
☐	☐	Sinus Pain
☐	☐	Sore Throat
☐	☐	Hoarseness
☐	☐	Allergies
☐	☐	Nosebleeds (epistaxis)

Y	N	**Pulmonary Symptoms**
☐	☐	Cough
☐	☐	Cough up Sputum
☐	☐	Blood
☐	☐	Shortness of Breath
☐	☐	Wheezing
☐	☐	Asthma

Y	N	**Cardiac Symptoms**
☐	☐	Chest Pain
☐	☐	Edema
☐	☐	Palpitations

Y	N	**Gastric Symptoms**
☐	☐	Decreases in Appetite
☐	☐	Heartburn
☐	☐	Difficulty in Swallowing
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Diarrhea
☐	☐	Constipation
☐	☐	Abdominal Pain
☐	☐	Rectal Bleeding
☐	☐	Black Stools

Y	N	**GU Symptoms**
☐	☐	Urinary Frequency
☐	☐	Urinary Incontinence
☐	☐	Painful Urination
☐	☐	Blood in Urine
☐	☐	Nocturia (urination >2x per night)

Y	N	**Musculoskeletal Symptoms**
☐	☐	Joint Pain
☐	☐	Muscle Aches
☐	☐	Muscle Weakness
☐	☐	Lower Back Pain

Y	N	**Neurological Symptoms**
☐	☐	Numbness
☐	☐	Tingling
☐	☐	Headache
☐	☐	Dizziness
☐	☐	Syncope
☐	☐	Convulsions

Y	N	**Skin Symptoms**
☐	☐	Lesions

Y	N	**Breast Symptoms**
☐	☐	Discharge
☐	☐	Lump

Y	N	**Endocrine Symptoms**
☐	☐	Excessive Thirst
☐	☐	Intolerance to Heat
☐	☐	Intolerance to Cold
☐	☐	Easy Bruising
☐	☐	Swollen glands in the Neck

Y	N	**Psych Symptoms**
☐	☐	Depression
☐	☐	Anxiety

Total Weight Loss Center

2790 Clay Edwards Dr., Ste. 600
North Kansas City, MO 64116

Health History

Patient Name: _____ **Date of Birth:** _____

Past Medical History *(check all that apply)*

Metabolic/Endocrine
- ☐ Chronic fatigue
- ☐ High cholesterol
- ☐ High Triglycerides
- ☐ Hypothyroidism
- ☐ Diabetes - Type 1
- ☐ Diabetes - Type 2
- ☐ Gout

Urological
- ☐ Urinary Stress Incontinence
- ☐ Kidney Disease
- ☐ Kidney Stones

Cardiovascular
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hypertension/High Blood Pressure
- ☐ Edema in Lower
- ☐ Extremities Arrhythmia
- ☐ Coronary Artery Disease
- ☐ Congestive Heart Failure
- ☐ Angina (Chest Pain)
- ☐ Defibrillator
- ☐ Pacemaker

Gynecologic (Women only)
- ☐ Menstrual Irregularity
- ☐ Polycystic Ovarian Syndrome

Neurological
- ☐ Severe Headaches
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Seizures

Respiratory
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ CPAP/BIPAP
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Blood Clot in Lung
- ☐ Emphysema
- ☐ Chronic Cough

Hematological
- ☐ Anemia
- ☐ Blood Clot in Legs
- ☐ Bleeding Disorder

Psychiatric
- ☐ Anxiety
- ☐ Anorexia/Bulimia
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Schizophrenia

Gastrointestinal
- ☐ Severe Heartburn
- ☐ Cholecystitis/Gallbladder Disease
- ☐ Hemorrhoids
- ☐ Hiatal Hernia
- ☐ Stomach Ulcers
- ☐ History of Colon Cancer
- ☐ Irritable Bowel Syndrome
- ☐ Fatty Liver
- ☐ Nausea/Vomiting
- ☐ Diarrhea/Constipation
- ☐ Cirrhosis/Hepatitis
- ☐ Pancreatitis
- ☐ Crohn's Disease

Cancer
- ☐ Location: _____

Musculoskeletal
- ☐ Arthritis
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Plantar Fasciitis
- ☐ Single/Multiple Joint Pain
- ☐ Tingling in Extremities

Other
- ☐ Hearing Impaired
- ☐ Vision Impaired

Other Medical History not Listed Above

_____

_____

_____

Surgical History

	Type of Surgery	Month/Year of Surgery
1.		
2.		
3.		
4.		
5.		

Total Weight Loss Center

2790 Clay Edwards Dr., Ste. 600
North Kansas City, MO 64116

Health History

Patient Name: _____ **Date of Birth:** _____

FAMILY HISTORY: PRESENT HEALTH OR CAUSE OF DEATH

	Father	Mother	Sisters	Brothers	Children
Living					
Deceased					
Year of Birth					
Age					
Diabetes					
Hypertension					
Heart					
Stroke					
Mental					
Cancer					
Unknown					
Additional Information					

Self Diets

Name of diet attempted	Approximate time on the diet & year	Amount of weight lost on the diet	Amount of weight regained
Example: Weight Watchers	*6 months in 1993*	*10 lbs.*	*15 lbs.*

Print

Save the completed form, attach and email it to Office@MeritasHealth.com.
Or, click **Print** to print the completed form and bring it to your next appointment.