Baum Weight Loss Program

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MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Today's Date: _____

DO YOU CURRENTLY HAVE OR HAVE HAD A HISTORY OF THE FOLLOWING?

☐ Diabetes: with use of ☐Pills ☐Insulin
☐ High Cholesterol/Hyperlipidemia
☐ Hyperthyroidism
☐ Insomnia
☐ Obstructive sleep apnea
☐ Congestive Heart failure/CHF
☐ COPD
☐ Anemia
☐ Stroke/CVA – any residual weakness
☐ Hepatitis: ☐A ☐B ☐C
☐ Incontinence
☐ High Blood pressure/Hypertension
☐ Hypothyroidism
☐ Atrial Fibrillation
☐ Depression/Anxiety
☐ Fibromyalgia
☐ Asthma
☐ Migraines/headaches
☐ GERD/reflux
☐ Cirrhosis
☐ Valley Fever/Coccidioidomycosis
☐ Arthritis
☐ Cancer *(If so, check the box that applies to your type of cancer)*

☐ Brain ☐ Lung ☐ Kidney ☐ Bone ☐ Thyroid
☐ Prostate ☐ Uterine ☐ Breast ☐ Bladder ☐ Ovarian

SURGERIES/DATES:

□ Pacemaker/Defibrillator: _____
□ Adenoids removed/Adenoidectomy: _____
□ Gallbladder removed/Cholecystectomy: _____
□ Gastric Sleeve: _____
□ Prostate Removal/Prostatectomy_____
□ Thoracic spine surgery: _____
□ Shoulder surgery- left/right _____
□ Finger surgery – left/right: _____
□ Knee surgery – left/right: _____
□ Foot surgery – left/right _____
□Ovaries removed/oophorectomy_____
□C-section_____
□Tonsils removed/Tonsillectomy: _____
□Appendix removed/Appendectomy: _____
□Abdominal surgery: _____
□Gastric Bypass: _____
□ Cervical spine surgery: _____
□ Lumbar spine surgery: _____
□ Wrist surgery- left/right _____
□ Hip surgery – left/right: _____
□ Ankle surgery – left/right: _____
□ Toe surgery – left right: _____
□Uterus removed/Hysterectomy: _____
□CABG: _____
□ Any other surgeries not listed above: _____

WOMEN:

LNMP/last normal menstrual period: _____ Date of last PAP: _____☐Normal ☐Abnormal ☐Biopsy
Number of pregnancies/Para: _____ Number of live births/Gravida: _____
Date of last Mammogram: _____ ☐ Normal ☐ Abnormal
Form of contraceptive? _____

PREVENTATIVE CARE WOMEN/MEN:

Date of last Bone scan/ DEXA Scan: _____ Facility Name: _____
Date of last Colonoscopy: _____ Doctors Name: _____

VACCINE / DATE GIVEN:

Date of Flu vaccine: _____ Date of pneumonia vaccine: _____
Date of Shingles Vaccine: _____ Date of Tetanus/DTap/Adacel: _____
Are you up to date with childhood vaccine? ☐ YES ☐ NO

SOCIAL HISTORY:

Any use tobacco product? ☐ YES ☐ NO If so, how many cigarettes per day? _____ ☐ CHEW
Any use of alcohol? ☐ YES ☐ NO If so, ☐ Daily ☐Weekly ☐ Socially and how many? _____
Any use of Marijuana? ☐ YES ☐ NO If so, ☐ Daily ☐Weekly ☐ Socially
Any use of recreational drugs? ☐YES ☐ NO *(Please list name of drug and how often)* _____

MEDICATIONS AND DOSE:

ALLERGIES AND REACTION'S TO MEDICATIONS/FOODS: