WHARTON MEDICAL CLINIC™
WEIGHT & DIABETES MANAGEMENT

PATIENT MEDICAL HISTORY FORM

Name on Health Card:	_____	Appointment Date:	_____
Date of birth:	_____	Home phone:	_____
E-mail address:	_____	Cell Phone:	_____

How did you hear about the Weight Management Clinic:

- ☐ friend / co-worker ☐ Yes ☐ No
  is your friend / co-worker a patient of the clinic?
- ☐ family member ☐ Yes ☐ No
  is your family member a patient of the clinic?
- ☐ internet ☐ family doctor ☐ phone book
- ☐ other (please describe):

_____

Social History:

Marital Status: ☐ Single ☐ Married

Is your spouse/partner overweight? ☐ Yes ☐ No

Do you have children? ☐ Yes ☐ No

If yes, how many children do you have? _____

How many of your children are overweight? _____

Profession: _____

Employment:
- ☐ 1. Homemaker
- ☐ 2. Unemployed
- ☐ 3. Volunteer
- ☐ 4. Retired
- ☐ 5. Disability
- ☐ 6. Part-Time _____
- ☐ 7. Full-Time _____

Education level (voluntary):

- ☐ 1. Less than high school
- ☐ 2. High school or GED
- ☐ 3. College
- ☐ 4. University

Self-Rated Health: Would you say your health in general is:

☐ 1. Excellent ☐ 2. Very Good ☐ 3. Good ☐ 4. Fair ☐ 5. Poor

Self-Rated Weight: How do you consider your weight?

☐ Obese ☐ Overweight ☐ About the right weight ☐ Under Weight

Ethnic Background (Voluntary):

- ☐ A. White / Caucasian
- ☐ B. South Asian (ex. Indian, Pakistani)
- ☐ C. East Asian (ex. Chinese, Korean)

D. Black:
- ☐ D1. African Black
- ☐ D2. West Indie Black
- ☐ D3. African American / Canadian

- ☐ E. Aboriginal
- ☐ F. Other, please specify:

_____

Please list any ALLERGIES to <u>medications</u>: _____ or ☐ None

Please list all current medications/supplements that you are taking below: (***you may attach a separate sheet)

Name of Medication	Strength (i.e. 500 mg)	Frequency (i.e. Once daily)
	/	/
	/	/
	/	/
	/	/
	/	/

TOLL FREE CENTRAL BOOKING LINE
1-855-210-0739

CLINIC LOCATIONS:
180 Vine St S, Suite 203 St. Catharines
2951 Walkers Line, Main floor Burlington
414 Victoria Avenue North, Hamilton
35 Upper Centennial Pkwy, Suite 2C - 2D Stoney Creek
658 Danforth Ave, Suite 402 Toronto - NEW
200 Ronson Dr, Suite 102 Etobicoke

Full Name: _____

Have you ever HAD or have been told you HAVE any of the following? Please check any medical conditions that apply:

CARDIOMETABOLIC:

- ❑ High Blood Pressure diagnosed by MD
- ❑ High Cholesterol diagnosed by MD
- ❑ Borderline / Pre diabetes diagnosed by MD
- ❑ Diabetes: ❑ Type 1 ❑ Type 2
  On insulin: ❑ Yes ❑ No

How long have you had diabetes? _____

Do you go to a diabetes clinic? _____

Do you see an endocrinologist or internist (diabetes doctor) at the diabetes clinic? ❑ Yes ❑ No

Does your family doctor run a diabetes clinic? ❑ Yes ❑ No

What do you use to treat your diabetes? (please check)

❑ Pills ❑ Insulin ❑ Diet controlled

Do you have any complications due to your diabetes?

❑ Yes _____ or ❑ No

If you have diabetes, please check the following:

Are your blood sugars under control? ❑ Yes ❑ No

Do you take your own blood sugars? ❑ Yes ❑ No

If yes, how often? _____

Are you seen by an eye doctor? ❑ Yes ❑ No

❑ Gestational Diabetes ❑ Yes ❑ No

❑ Kidney disease ❑ Yes ❑ No

❑ Heart Disease ❑ Angina ❑ Heart Failure

❑ Heart Attack? Year: _____

Are you followed by a Cardiologist/Cardiac Specialist?

❑ Yes ❑ No

If yes, who: _____

❑ Stroke (or TIA's) Year: _____

MECHANICAL:

- ❑ Obstructive Sleep Apnea
- ❑ Using CPAP machine
- ❑ Osteoarthritis
  Joint(s): _____
- ❑ Osteoporosis/Osteopenia
- ❑ Auto-immune
- ❑ Hypothyroidism
- ❑ Cancer Type: _____
  Treatment: _____ Year: _____
- ❑ Deep Vein Thrombosis, DVT (blood clot in the leg)
- ❑ Pulmonary Embolism, PE (blood clot in the lungs)
- ❑ Anemia (low iron in the blood)

GASTROINTESTINAL

- ❑ Gallstones ❑ Gallbladder removed Year: _____
- ❑ Fatty Liver
- ❑ GERD (heartburn)
- ❑ Crohn's
- ❑ Ulcerative Colitis
- ❑ Other Bowel Conditions: _____

PSYCHOLOGICAL

- ❑ Depression diagnosed by MD
- ❑ Anxiety Disorder diagnosed by MD
- ❑ Bipolar Disorder diagnosed by MD
- ❑ Binge Eating Disorder diagnosed by Psychiatrist

Polycystic Ovarian Syndrome (PCOS) Questionnaire (Women only)

Have you ever been diagnosed with PCOS by an MD? ❑ Yes ❑ No

If yes, did this include fertility? ❑ Yes ❑ No

Full Name: _____

Obstructive Sleep Apnea (OSA) Questions

Do you snore loudly? ❑ Yes ❑ No

Have you ever been told that you stop breathing, or have pauses in breathing during the night? ❑ Yes ❑ No

If you answered yes to any of the above 2 questions, you will need to fill out the *OSA questionnaire*

Please List all Specialist that you see (i.e.: nephrologist, psychiatrist, endocrinologist, etc):

_____

_____

_____

Operations and Hospitalizations:

❑ Weight Loss Surgery (Gastric Bypass/ Gastric Sleeve/Lap Band) Year: _____ Surgeon's Name: _____

❑ Heart Surgery Year: _____ Surgeon's Name: _____

❑ Knee Replacement Year: _____ Surgeon's Name: _____

❑ Hip Replacement Year: _____ Surgeon's Name: _____

Please add any additional medical problems or surgeries in the space below:

Medical Problem	Surgery or Procedure	Date of Surgery

Family History:

Please check all that apply in regards to your family members (please **only** indicate: Mother, Father, Brother, Sister):

❑ Overweight/Obese ❑ Heart Attack/Disease ❑ Diabetes

_____ _____ _____

_____ _____ _____

_____ _____ _____

Smoking:

❑ Current: Packs/Day: _____ ❑ Quit Year: _____ ❑ Never Smoked

Alcohol Use:

❑ Yes Drinks/Day or Month: _____ ❑ No

Full Name: _____

What are your main reasons for weight loss? ☐ To improve health ☐ Mobility ☐ Esthetics/Appearance

☐ Other _____

Was there an event triggering weight gain? ☐ No ☐ Yes If Yes, please check all that apply.

☐ Pregnancy ☐ Injury ☐ Illness ☐ Stress ☐ Medications ☐ Other

What was your MAXIMUM weight since age 18 (not counting pregnancy)? ☐☐☐ pounds (lbs)

What was your LOWEST weight since age 18? ☐☐☐ pounds (lbs)

Have you lost weight and regained it? ☐ No ☐ Yes

If yes, number of times you lost : ☐☐ 5lbs ☐☐ 10lbs ☐☐ 25lbs ☐☐ 50lbs ☐☐ 100lbs (pounds)

Age at which you were first considered overweight:

☐ 1-5 ☐ 5-10 ☐ 10-15 ☐ 15-20 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60 ☐ Over 60 (years)

Have you tried any of the following methods to lose weight?

☐ Self-directed diet ☐ Self-directed exercise ☐ Personal Trainer/Gym Membership

☐ Diet Book (Atkins, South Beach, Dr. Phil etc.) _____

☐ Structured Program (Weight Watchers, Jenny Craig etc.) _____

☐ Meal Replacement (e.g. Slimfast) or every low calorie diets (e.g. Optifast) _____

☐ Commercial medical programs (e.g. Dr. Bernstein etc.) _____

☐ Non-prescription weight loss medications/supplements: _____

☐ Prescription weight loss medications: _____

☐ Surgery : _____

Are you currently in another weight loss program? ☐ No ☐ Yes What program? _____

Are you interested in hearing about surgical procedures for weight loss? ☐ No ☐ Yes

Are you currently physically active?

☐ No ☐ Yes If yes, please specify the number of days per week you are physically active: ☐ days per week

How many meals do you eat per day? ☐☐

Do you have problems with portion control? ☐ Yes ☐ No

Are you an emotional eater? ☐ Yes ☐ No

Do you wake up at night to eat? ☐ Yes ☐ No

My weaknesses for foods include (check all that apply) ☐ Carbs ☐ Salty ☐ Fat ☐ Sugar

I eat fruits and vegetables ☐ Yes ☐ No ☐ Very little

I eat ☐ quickly ☐ slowly

I drink (check all that apply) ☐ water ☐ coffee ☐ tea ☐ juice ☐ pop ☐ diet pop

The majority of food I eat is ☐ after 6 pm ☐ before 6 pm

What is your ultimate weight goal ☐☐☐ pounds (lbs). What would be a realistic goal weight for you to reach

☐☐☐ pounds (lbs). At what weight would you still be disappointed ☐☐☐ pounds (lbs).

Please list a behavioral goal/functional goal that you would like to achieve: _____

_____