UPMC
Life After Weight Loss Program
New Patient Health History Form

Patient Name: ______________________________ Birth date: __________________ Today's Date:____________

Referring Physician: _______________________________ Address: ______________________________________

Pharmacy Name: ____________________________________ Phone: ___________________________________

Reasons for today's visit: ____

Briefly describe the problem: ____

____

____

Please list prior surgeries:

Please list current and prior illnesses or injuries:

Please list all medications (prescriptions and non-prescriptions) that you take. Please include herbal remedies, vitamins, over-the-counter, illegal drugs

Do you take any blood thinning products such as Vitamin E, Plavix, Coumadin, or Aspirin?

□ Yes □ No

Do you have any food, environmental or drug allergies?

□ Yes, please explain: Allergy type: ____

Reaction: ____

□ No

Do you smoke?

□ Yes, please specify type (cigarettes, pipe, etc.): ______________________________

How many a day: ______________________________

How long have you smoked: ______________________________

□ No

Do you drink alcohol?

□ No □ Socially □ Daily

□ Beer/wine □ Hard liquor

Occupation: ____

Hand dominance: □ Right □ Left

Please describe any family health issues below

Mother:

Father

Sibling(s)

Other hereditary conditions

Patient Signature: ____________________________________ **Date:** __________________

Physician Signature: __________________________________ **Date reviewed:** __________

Health History Form (page 2)

Do you now have or have you ever had:

Fever or chills	□ No	□ Yes, please explain ______________________________
Unexplained weight loss	□ No	□ Yes, please explain ______________________________
Hepatitis	□ No	□ Yes, please explain ______________________________
HIV/Other blood diseases	□ No	□ Yes, please explain ______________________________
Bleeding disorders	□ No	□ Yes, please explain ______________________________
Thyroid problems	□ No	□ Yes, please explain ______________________________
Diabetes	□ No	□ Yes, please explain ______________________________
Arthritis	□ No	□ Yes, please explain ______________________________
Mobility/joint problems	□ No	□ Yes, please explain ______________________________
Constipation	□ No	□ Yes, please explain ______________________________
Diarrhea	□ No	□ Yes, please explain ______________________________
Blood in stool	□ No	□ Yes, please explain ______________________________
Nausea/vomiting	□ No	□ Yes, please explain ______________________________
Liver problems	□ No	□ Yes, please explain ______________________________
Heart problems	□ No	□ Yes, please explain ______________________________
Deep vein thrombosis/DVT	□ No	□ Yes, please explain ______________________________
Blood clots in lungs/legs	□ No	□ Yes, please explain ______________________________
High blood pressure	□ No	□ Yes, please explain ______________________________
Asthma	□ No	□ Yes, please explain ______________________________
Sleep Apnea	□ No	□ Yes, please explain ______________________________
Breast abnormalities	□ No	□ Yes, please explain ______________________________
Nipple discharge	□ No	□ Yes, please explain ______________________________
Last mammogram		Date: _____/_____/_____
Changes in moles	□ No	□ Yes, please explain ______________________________
Lesions	□ No	□ Yes, please explain ______________________________
Rashes	□ No	□ Yes, please explain ______________________________
History of Keloids	□ No	□ Yes, please explain ______________________________
Neurological problems	□ No	□ Yes, please explain ______________________________
Headaches	□ No	□ Yes, please explain ______________________________
Genital or oral herpes	□ No	□ Yes, please explain ______________________________
Sexually transmitted diseases	□ No	□ Yes, please explain ______________________________
Blood in urine	□ No	□ Yes, please explain ______________________________
Urinary tract infection	□ No	□ Yes, please explain ______________________________
Problems urinating	□ No	□ Yes, please explain ______________________________
Prostate problems	□ No	□ Yes, please explain ______________________________
Kidney problems	□ No	□ Yes, please explain ______________________________
Vision problems	□ No	□ Yes, please explain ______________________________
Hearing problems	□ No	□ Yes, please explain ______________________________
Sinus problems	□ No	□ Yes, please explain ______________________________
Mood swings	□ No	□ Yes, please explain ______________________________
Sleep apnea	□ No	□ Yes, please explain ______________________________

Please list any other conditions/illnesses not indicated above: ________________________________

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To the best of my knowledge, this information is complete and correct. I understand that it is my responsibility to inform my doctor if there are any changes in my health.

Patient Signature: ________________________________ **Date:** ______________________

Physician Signature: ________________________________ **Review date:** _______________