Dr. Mark Pinsky's
MEDICAL
WEIGHT LOSS CLINIC
Transforming you to Optimal Health

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR FIRST VISIT

Date: _____

Name: _____Age:_____ DOB:_____ Sex: M F

Email:_____Phone_____

Street Address_____

City_____State_____Zip_____

Primary Care Physician: _____ Phone: _____

Other Physicians:_____

Whom do we thank for your referral to us? _____

Emergency Contact:

Name_____Relationship to you_____

Contact info_____

Release of Medical Information:

I_____give Dr. Mark Pinsky's office staff my permission to release medical information which includes: medication information, lab and diagnostic test results, and appointment dates and times to the following people.

1._____

2._____

3._____

I give my permission to Dr. Mark Pinsky's office staff to leave detailed messages at the following numbers.

1._____

2._____

Signature_____Date_____

Medical History Form

Present Medical Status:

Any allergies to medications? Yes No
Please specify:_____

Are you taking any medications, vitamins, or herbals? Yes (please list below) No

Medication	dose	frequency	Medication	dose	frequency

Are you in good health at the present time to the best of your knowledge? Yes No
Please list all medical conditions, surgeries and hospitalizations:

Past Medical History: (check all that apply)

_____ acid reflux	_____ alcohol abuse	_____ anorexia nervosa
_____ anxiety	_____ ankle/leg swelling	_____ arthritis
_____ asthma	_____ bone fracture (<90 days)	_____ bipolar disease
_____ bulimia	_____ cancer; type _____	_____ chronic pain
_____ depression	_____ diabetes; type_____	_____ drug use
_____ eye disease	_____ fatty liver disease	_____ glaucoma
_____ gout	_____ heart disease	_____ heart attack
_____ high blood pressure	_____ high cholesterol	_____ hyperthyroidism
_____ irregular heart beat	_____ kidney disease	_____ kidney stones
_____ liver disease	_____ low back pain	_____ migraines
_____ metabolic syndrome(pre-diabetes)		_____ palpitations
_____ polycystic ovary syndrome	_____ prior use of phen-fen	_____ sleep apnea
_____ snoring	_____ stroke	_____ ulcers
_____ valve disorder		

Surgeries:

_____ gall bladder removal	_____ appendix removal	_____ groin hernia
_____ hysterectomy	_____ coronary stent	_____ coronary angioplasty
_____ gastric bypass surgery	_____ lap band	_____ back surgery

Gynecologic History:

Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual Onset: _____
Duration: _____
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: _____

Social History:

Have you ever smoked cigarettes or used other forms of tobacco? Yes No
If yes, how many packs per day? _____
Number of years smoked? _____
If quit, when? _____

Do you drink alcohol? Yes No
How many drinks per week? _____ [1 drink is: 1 glass wine (4 oz), 1 beer (12 oz), hard liquor (1 oz)]

What is your occupation? _____

Circle appropriate choice: Married Single Divorced Widowed Domestic Partner

Do you drink coffee or tea? Yes No How much daily? _____
Do you drink non-diet cola drinks? Yes No How much daily? _____
Any other sources of caffeine? Yes No How much daily? _____
How many hours per night do you sleep (on average)? _____

Family History:

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

Has any blood relative ever had any of the following:
Heart Disease/Stroke Yes No Who: _____
Diabetes: Yes No Who: _____
High Blood Pressure Yes No Who: _____
High Cholesterol: Yes No Who: _____
Kidney Disease: Yes No Who: _____
Psychiatric Disorder Yes No Who: _____

Nutrition Evaluation:

Any history of binge eating, purging or starvation? Yes No

Do you eat more than 25% percent of your calories after dinner? Yes No

Present Weight:_____ Height (no shoes): _____ Desired Weight: _____

What weight you would be satisfied with? (For example, if you did not attain your desired weight, what weight would you accept?)_____

In what time frame would you like to be at your desired weight? _____

Birth Weight:_____ Weight at 20 years of age: _____ Weight one year ago: _____

What is the main reason for your decision to lose weight? _____

When did you begin gaining excess weight? (give reasons, if known): _____

What has been your maximum lifetime weight (non-pregnant) and when?_____

How many diets have you been on (state the number)? _____

Previous diets you have followed:

_____
_____
_____
_____

Give dates and results of your weight loss:

_____
_____
_____
_____

What do you feel are your main reasons for being overweight?

_____
_____
_____

Is your spouse, fiancé or partner overweight? Yes No

By how much is he or she overweight? _____

How often do you eat out? _____

What restaurants do you frequent?_____

How often do you eat "fast foods?"_____

Who plans meals? _____ Cooks? _____ Shops? _____

Do you use a shopping list? Yes No

What time of day and on what day do you shop for groceries? _____

Food allergies:_____

Food dislikes: _____

Food you crave: _____

Any specific time of the day or month that you crave food? _____

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

Do you awaken hungry during the night? Yes No
If so, what do you do? _____

What are your worst food habits? _____

Snack Habits:

What? _____ How much? _____ When? _____

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

_____

_____

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

_____

_____

Typical Breakfasts	Typical Morning Snacks	Typical Lunches
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____
Typical Afternoon Snacks	**Typical Dinners**	**Typical Evening Snack/Desserts**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Describe your usual energy level: _____

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, running, swimming or cycling.
___Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in running, 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.

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.

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

How confident are you that we can help you with your weight problem? _____
_____
_____

Why is this the right time for you to lose weight? _____
_____
_____

Are there any other issues that you think are important that we should know? _____
_____

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