

**Foxkins Diamond Program for Weight Management
New Patient Health History**

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

REVIEW OF SYSTEMS: Please circle each of the following as if the questions begins with "Are you":

Constitutional

- 1. Feeling weak / tired all the time? No Yes
- 2. Having trouble sleeping? No Yes
How many hours do you sleep at night? _____
- 3. Gaining / losing weight? (circle one) No Yes
How many pounds a month? _____
Since when? (month, year) _____
- 4. Having fevers / chills? No Yes
- 5. Do you exercise at least 30 min/day? No Yes
Type of exercise? _____
How often? X _____ day(s), x _____ week

Eye, Ear, Nose, Throat:

- 1. Having mouth sores? No Yes
- 2. Having visual problems? (eg. @ night) No Yes

Cardiovascular:

- 1. Having a problem with swelling of arms/legs/ankles?
- 2. Having palpitations/racing heart beats? No Yes
- 3. Having chest pains? No Yes
- 4. Having fainting spells? No Yes
- 5. Shortness of breath climbing stairs? No Yes
How many stairs? _____
- 6. Having problems with blood pressure? No Yes
- 7. Having calf pain? No Yes

Respiratory:

- 1. Having wheezing? No Yes
- 2. Shortness of breath? No Yes
- 3. Having problems with sleep apnea? No Yes
Using a CPAP/BiPAP machine? No Yes

Gastrointestinal/Abdominal:

- 1. Having a problem with nausea? No Yes
- 2. Vomiting? No Yes
- 3. Regurgitating(feedback)? No Yes
- 4. Vomiting blood? No Yes
- 5. Having heartburn? No Yes
- 6. Having indigestion? No Yes
- 7. Having abdominal pain? No Yes
Where? _____
How long? _____
- 8. Having a problem with diarrhea? No Yes
Time/day _____ Times/week _____
- 9. Constipated? No Yes
Last bowel movement _____ day(s) ago
My stools are: formed hard
- 10. Having blood in your stools? No Yes

Musculoskeletal:

- 1. Having pain in any of the following areas:
Back? No Yes Knee? No Yes
Hip? No Yes Ankle? No Yes
Wrist No Yes Arm? No Yes
Neck? No Yes Shoulder? No Yes
Experiencing fibromyalgia? No Yes
- 2. Experiencing carpal tunnel syndrome? No Yes

Integumentary/Breast:

- 1. Losing excessive amounts of hair? No Yes
- 2. Having a rash under breasts? No Yes
Abdominal fold? No Yes
Seen a dermatologist? No Yes
- 3. Having breast lumps or nipple discharge? No Yes

Neurological:

- 1. Having trouble with balance/coordination? No Yes
Been in the ER because of falls? No Yes
- 2. Having recurrent headaches? No Yes
- 3. Having seizures? No Yes
- 4. Having episodic weakness? No Yes
- 5. Having numbness/tingling? No Yes
- 6. Having pain down the
Thigh / leg/ arm? (circle) No Yes
- 7. Having memory loss? No Yes

Psychiatric:

- 1. Depressed? No Yes
Suicidal/Homicidal thoughts? No Yes
- 2. Stressed? No Yes
From: Spouse Significant other
Family Friends Finances Job

Endocrine:

- 1. Having problems with:
--sugar control (diabetes)? No Yes
On insulin? No Yes
--your thyroid gland? No Yes
On medication? No Yes
--cholesterol / triglycerides? No Yes
On medication? No Yes
- 2. Having numbness / tingling? No Yes
Where? _____
Spasms? __ Where? _____

Hematologic/Lymphatic:

- Do you have a history of anemia? No Yes

Genitourinary:

- 1. Having urinary leaks
coughing/sneezing? No Yes
- 2. Having difficulty voiding? No Yes

Gynecological:

- Birth control: _____ Last period _____
- Date of last pap exam: _____
Normal? _____ Abnormal? _____
- If abnormal, is there a history of abnormal? No Yes
- How many pregnancies? _____ Births? _____
- Vaginal Delivery? _____ C-Sections? _____
- Having problems with menstruation? No Yes

SURGICAL HISTORY:

Type	Date

HOSPITALIZATIONS:

Reason	Date

ALLERGIES:

Are you allergic to (please circle which one/s):

medications / supplements / food

latex / contrast dye / iodine

List allergies:

IMMUNIZATIONS:

Last tetanus: _____

Flu shot: _____

Pneumovax: _____

SOCIAL HISTORY:

Marital Status: _____

Current Occupation: _____

Past or Current use of:

Tobacco products No Yes

Alcohol No Yes

Recreational Drugs No Yes

Do you attend support group meetings? No Yes

Date last attended: _____

Where? _____

The information I have given on this form is both correct and complete to the best of my ability.

Patient Signature

Reviewed by:

Provider Signature