Mercy

Mercy Clinic Weight and Wellness

Patient History Form

Name:_____ Date of Birth: _____

Current Medications	Dose	# Times per day	How long have you taken this?
1)			
2)			
3)			
4)			
5)			
6)			

Allergies	Reaction that occurs (rash, hives, etc)
1)	
2)	
3)	

Past Medical History	A. Yourself	B. Family
1. Overweight		
2. Diabetes		
3. Hypoglycemia (Low Blood Sugar)		
4. HighBloodPressure		
5. High Cholesterol		
6. Heart Attack		
7. Stroke		
8. Bypass Surgery		
9. Angina		
10. Cancer		
11. HIV		
12. Kidney Disease		
13. Psychiatric History (anxiety, depression, bipolar, PTSD, etc.) If yes, are you currently working with a behavioral health provider? Yes No If yes, name & phone number_____ (we will request your permission to contact this provider)		
14. Orthopedic Problems (Knees & Joints)		

Other Illnesses

1) _____ 2) _____

3)_____ 4) _____

Social History *(check one)*	Yes	No		
Smoking	☐	☐	Packs/day:_____	Year started: _____
Alcohol	☐	☐	Quantity:_____	per day week month
Exercise	☐	☐	Type: _____	Frequency:_____
Recreational drugs	☐	☐	Type: _____	Frequency:_____

BMI:_____

Anthropometric Information:

Current Weight:_____

Height:_____