NW Metabolic Medicine

nwmetabolic.com

MEDICAL HISTORY

Patient Name (Last, First, Initial)	☐ Male ☐ Female	Date of Birth	Today's Date

PAST MEDICAL HISTORY

Please check any conditions for which you have previously been diagnosed and treated (or are still currently being treated for):

☐ Diabetes (specify: ☐ Type 1 ☐ Type 2)
☐ Pre-diabetes ("borderline diabetes")
☐ Gestational diabetes
☐ Insulin resistance / Metabolic syndrome
☐ Polycystic ovarian syndrome (PCOS)

☐ High blood pressure
☐ Heart attack (specify year: _____)
☐ Stroke (specify year: _____)
☐ Congestive heart failure
☐ Heart murmur / valve problems
☐ Atrial fibrillation
☐ Pacemaker
☐ Defibrillator

☐ Anemia
☐ Blood clots (specify: ☐ legs ☐ lungs)

☐ Cholesterol problems
☐ Thyroid disorders (specify: ☐ Low ☐ High)

☐ Asthma
☐ Glaucoma
☐ Insomnia
☐ Vitamin D deficiency

☐ Seizures
☐ Migraines

☐ Heartburn/stomach ulcer
☐ IBS
☐ Crohn's disease
☐ Celiac disease / gluten sensitivity
☐ Pancreatitis

☐ Kidney problems (other than UTI)
☐ Kidney stones
☐ Liver disease

☐ Gout

☐ Cancer (specify type: _____)

☐ Depression
☐ Anxiety
☐ Bipolar disorder
☐ Eating disorder
☐ ADD/ADHD

☐ Other (specify: _____)

Have you been diagnosed with non-Rx allergies? ☐ No (if Yes, specify: ☐ food and/or ☐ respiratory [e.g.: hay fever, pollen, dust])

Have you ever been *tested* for sleep apnea? (specify: ☐ No ☐ Yes, year tested: _____)
Have you ever been *diagnosed* with sleep apnea? (specify: ☐ No ☐ Yes)
Do you use CPAP/BiPAP? (specify: ☐ No ☐ Yes)

PAST SURGICAL HISTORY

Weight loss surgeries:
- ☐ Roux-en-y
- ☐ Gastric sleeve
- ☐ Lap band

Any other major surgeries: _____

WELLNESS AND HEALTH MAINTENANCE HISTORY

Most recent lab testing (specify year): _____
If over age 50, date of last colonoscopy: _____

Last pap smear (specify year): _____
Last mammogram (specify year): _____
Menopause (specify year): _____

Over →

SOCIAL HISTORY

Occupation (past, if retired): _____ ☐ Retired / Not currently working

Spouse / significant other name: _____

Marital status: _____

Age(s) of any children living at home: _____

Tobacco use: _____

Drug and alcohol use:		Currently use	Previously used	Frequency per week	If stopped, when
	alcohol	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
	recreational drugs	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____
	medication misuse	☐ No ☐ Yes	☐ No ☐ Yes	_____	_____

FAMILY HISTORY

Has anyone in your family (blood relatives) had any of the following? (Check appropriate box)

	Mother	Father	Grand-parent	Brother/ Sister	Other (specify)
Diabetes or borderline diabetes	☐	☐	☐	☐	_____
Heart disease/heart attack/congestive heart failure	☐	☐	☐	☐	_____
Cholesterol problems	☐	☐	☐	☐	_____
High blood pressure	☐	☐	☐	☐	_____
Hypothyroidism	☐	☐	☐	☐	_____
Stroke	☐	☐	☐	☐	_____
Anxiety, depression or mental health issues (e.g., depression, bipolar disorder, etc.)	☐	☐	☐	☐	_____
Drug/alcohol/medication abuse	☐	☐	☐	☐	_____
Weight problems	☐	☐	☐	☐	_____

MEDICAL PROVIDER INFORMATION

Primary care provider: _____

Specialist(s): _____

SYMPTOMS (REVIEW OF SYSTEMS)

Please check any issues that you are currently experiencing, or have experienced within the past two months:

☐ Chest pain
☐ Shortness of breath
☐ Fatigue
☐ Persistent difficulty sleeping
☐ Mobility problems
☐ Pain in joints (specify): _____
☐ Rash/irritations in skin folds
☐ Extreme hunger
☐ Strong food cravings
☐ Diarrhea
☐ Constipation
☐ Heavy or painful periods
☐ Irregular periods
☐ PMS

MEDICATION ALLERGIES

Have you experienced a reaction to, or are allergic to any medications? (specify: ☐ No ☐ Yes)
If Yes, please list:

_____ _____

_____ _____

CURRENT MEDICATIONS AND SUPPLEMENTS

Please provide a complete list of all prescription medications (including birth control medication), over-the-counter medications, and supplements that you are taking. Note: you do not need to fill out this portion of form if you have a separate list with these details.

Prescription medications:

Name	Dosage	Frequency

For Women – Contraception (if applicable)

Form of contraception (e.g., birth control pill, IUD, Nexplanon, tubal ligation, etc.): _____

☐ Partner has vasectomy

Over-the-counter medications:

_____

_____

_____

_____

_____

Vitamins and supplements:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____