WEIGHLESS MD
AND WELLNESS

Health History Form

262-226-2046

TODAY'S DATE:			
Patient name:		male	female
Date of birth:		Age:	
Referring physician or Primary Care Physician: (Please complete full name)			
Patient Address:	City:	State:	Zip:
Email:			
Home phone:	Cell:		

Work status: employed not employed retired disabled student

***Must Complete: Former Vitality Patient: YES N0 If yes, last date seen:

Please list all allergies: Include medication, food allergies and food sensitivities

Please list all medications you are taking: Include vitamins and other supplements

Medication or supplement	Dose	Times Taken	Reason for Taking and for how long?

Please list your past surgeries and year (if known):

____
____
____
____

Check any medical problems (past and present):

heart problems__________________________________ chronic pain________________________________

high blood pressure______________________________ arthritis____________________________________

cancer_________________________ if so, please specify type and year ______________________________

kidney problems_________________________________ depression___________________________________

diabetes_______________________________________ anxiety_____________________________________

bowel problems_________________________________ stomach problems (reflux)_____________________

blood clots_____________________________________ sleep problems _______________________________

list any other medical problems____

Date of last doctor visit with bloodwork?

Did you bring a copy of bloodwork in?

Please list 3 major health concerns in order of importance.

1.

2.

3.

Please list 3 Goals that you would like to accomplish in your Journey for improved wellness.

1.

2.

3.

Please Rate your level of Readiness for change: _________ (1- not ready, still confused 10- very ready for a change)

Please explain why you came in today and how we can best help you?

Please explain why you might change and why this is important to you?

Female Patients ONLY:

menstruating pre-menopause post-menopause

If still menstruating, date of last period ________________ Taking birth control yes no

Do you exercise? yes no Types of exercise?

How often?

Do you smoke? How much? Are you a former smoker?

Do you drink alcohol? What type? How much per day/week?

Do you drink caffeine? How much?

Do you drink water? How much?

Do you drink sugar or sugar free beverages? If yes, how much?

How did you hear about us?

Are you experiencing any of the following symptoms?

- **Bloating/constipation/diarrhea**
- **Belching/burping/indigestion**
- **Stomach pain**
- **Frequent use of antibiotics**
- **Frequent infections (cold, sinus, respiratory)**

Dysbiosis

- **Gas**
- **Sugar cravings**

- **White coating on tongue**
- **Brain fog/forgetfulness**
- **Rectal itching**
- **Bad breath or bad taste in mouth**
- **Intolerance to vegetables, fruit or high fiber foods**

Low stomach acid

- **Gas immediately following a meal**
- **Reflux**
- **Belching**
- **Fullness after a meal**

Toxicity

- **Sensitive to smells**
- **Regular use of fertilizer or round up**
- **Feel better when away from home**
- **Bitter taste in mouth**
- **Tired in warmer climates**

Liver/Gallbladder

- **History of gall bladder attacks or stones**
- **Gall bladder removal**
- **Itchy or red inflamed skin**
- **Yellow cast to eyes**
- **Stools that are grey or green**
- **Stools with mucous**