Jibrini MD & Associates

Internal Medicine & Weight Loss Management

NEW PATIENT FORM

Name:______________________________ **Birthdate:**______________ **SS#**________________

Phone #____________________ **Martial Status:**______________

Address:____ **Allergies:**_______________________

____

Emergency Contact

Name:_______________________________ Relationship:__________ Phone:__________

Patient's Spouse:______________________ Phone:__________

Family Physician:______________________ Phone:__________

Referred by:__________________________

Medications:**(list all prescriptions, over the counter,vitamins)**_______________________________________

____

Birth Control: Yes or No

Weight History

When did you first become overweight? (Your age then)___________________ (Year)_____________

How did your weight gain start? Describe any circumstances:____

____

What do you think is the cause of your weight problem?____

____

Your present weight:__________Your weight goal:_________________Height:___________

What was your highest weight? (excluding pregnancy)_____Your age then________# of years ago:___________

What was your lowest weight?____________ Your age then ___________ # of years ago:______________

Have you ever stayed the same weight for 10 years or more? Yes/No

Have you attempted to lose weight before?________most lbs lost?___________how long it took:____________

Describe previous methods of weight loss (e.g. diets pills, injections, hypnosis, acupuncture) and describe your results. (If on previous diet pills, give approximate dates: ____

Past Medical History

(Only circle if the answer if yes)

Anemia	yes or no
Atrial fibrillation	yes or no
Depression	yes or no
Diabetes	
Heart attack	yes or no
High blood pressure	yes or no
High cholesterol	yes or no
Menopause	yes or no
Stroke	yes or no
Thyroid Disease	yes or no

Surgical History

(please circle ones that apply to you)

Ablation
cesareansection
Hysterectomy
thyroidectomy
tubal ligation
vasectomy

Social History

(End date or age if former drug, tobacco,alchol user)

Caffeine	yes or no
Current Smoker	yes or no
Alchol use	yes or no
Past drug use	yes or no
Abused	yes or no

Family History

(please state which family member it applies to)

Anemia	yes or no
Depression	yes or no
Diabetes	yes or no
Heart Disease	yes or no
High cholestrol	yes or no
hypertension	yes or no
stroke	yes or no

Last Menstrual Period _____________