Wellness District Medical Weight Loss
_____
Spencer Berry, MD Medical Director

435 32nd Ave. E. Suite B
West Fargo, ND 58078

Phone: 701-205-3088
Fax: 701-335-7808
www.fargowellnessdistrict.com

New Patient History

(Please PRINT All information clearly) Date: ____/____/___

Name _____ Date of Birth____/____/____ Age ____
Your Address _____ City/State _____ Zip _____
Social Security#: _____/_____/_____ Are you on Medicare? _____
☐Home Phone: ( ) _____-_____ ☐Work: ( ) _____-_____ ☐Cell: ( ) _____-_____
Please indicate which phone number you would like for us to use as your primary number.
Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-binary/non-conforming ☐ Prefer not to respond
Email address: _____ ☐Would you like email reminders
Primary Physician_____ PCP Phone #_____
Preferred Pharmacy: _____ Pharmacy Phone: _____
Occupation: _____ Employer Name: _____
Shifts worked: (Day/PM/Night) _____

Height_____
Current Weight_____
Lifetime Heaviest Weight (non-pregnant) _____ Age at Heaviest Weight_____
Goal Weight _____ Age last at Goal Weight_____
Have you ever had bulimia, anorexia or Binge eating disorder? _____
Do you Smoke? _____ If yes how much/day? _____ How many years have you smoked? _____
How many alcoholic beverages do you consume in a week? _____

WOMEN:

Are you Pregnant? _____ Are you Breastfeeding? _____ Are you menopausal or premenopausal? _____

MEDICAL HISTORY:

Have you had any serious illness in the past that has led to hospitalization? (Please List)
_____
Have you had any surgeries? (Please List)_____
_____

Please circle if you have been having any of the following symptoms

1) Weakness
2) Dry, Coarse skin
3) Tired/fatigue
4) Slow speech
5) Slow Movement
6) Coldness and cold skin
7) Diminished sweating
8) Thick tongue
9) Coarse hair
10) Pale skin
11) Constipation
12) Gain in weight
13) Loss of hair
14) Difficulty breathing
15) Swollen feet
16) Hoarseness
17) Loss of appetite
18) Poor memory
19) Nervousness
20) Heart palpitations
21) Brittle nails
22) Swelling of face & eyelids
23) Excessive/painful menses
24) Emotional Instability
25) Depression
26) Headache

Please check if none of the above 26 symptoms apply to you_____.

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Please check the medical conditions that YOU have been diagnosed with in the past or currently.

☐ Past or current drug or alcohol problems
☐ Depression or anxiety
☐ Diabetes: Type 1(juvenile) or 2(adult)?
☐ Gestational Diabetes
☐ Insulin Resistance/Prediabetes/Borderline Diabetes/Dysmetabolic Syndrome
☐ Polycystic Ovarian Syndrome
☐ Heart Burn
☐ Glaucoma (open or Narrow Angle?)
☐ High Cholesterol
☐ High Blood Pressure
☐ Heart Disease/Heart Attack/Heart Failure
☐ Arrhythmia
☐ Heart Valve Problems / Heart Murmurs
☐ Do you have a pacemaker: yes or no
☐ Do you have a defibrillator: yes or no
☐ History of passing out (syncope)
☐ Asthma
☐ Other Lung diseases (Type: _____
☐ ADHD (Attention deficit disorder)
☐ Bipolarism or other psychiatric conditions? _____
☐ Kidney Diseases (Type: _____)
☐ Obstructive sleep apnea (use a CPAP?)
☐ Insomnia / other sleep disorders
☐ Thyroid Disorders (Low or High or Other: _____)
☐ Other Chronic Medical Conditions: _____

Do you have any know Drug allergies? If yes, please explain:

_____

Current meds and doses:	**Taking it for?**	**Over the counter meds/vitamins/herbals**
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____
5) _____	_____	_____
6) _____	_____	_____

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WHO in your **FAMILY** has had the following? (mom, dad, siblings, aunts/uncles, cousins, grandparents)

- Heart disease/Heart Attack/Congestive Heart Failure _____
- Cancer (list type) _____
- High Cholesterol _____
- Sudden death < age 40 from a medical condition _____
- Diabetes or borderline diabetes _____
- Mental illness (depression, bipolar, etc.) _____
- Who in family struggles with weight? _____
- Other family medical conditions _____
- Hypothyroidism _____
- High Blood Pressure _____
- Strokes _____

EXERCISE

Frequency?	What is the *intensity?*	For *how long?*
☐ None	☐ None	☐ None
☐ 1-2x/week	☐Light (brisk walking, golfing, doubles tennis)	☐ Under 10 minutes
☐ 3-5x/week	☐ Moderate (biking, low impact aerobics)	☐ 10-20 minutes
☐ Daily	☐ Very hard (Sprinting, speed swimming)	☐ over 30 minutes

Do you have any physical restrictions to exercise? (what are they) _____
Do you make yourself sick because you feel uncomfortably full? Y or N
Do you worry you have lost control over how much you eat? Y or N
Have you recently lost more than 15 pounds in a three-month period? Y or N
Do you believe yourself to be fat when others say you are too thin? Y or N
Would you say that food dominates your life? Y or N

What weight-loss programs have you tried in the past? _____
_____
Did they work? Why or why not? _____

What do you hope to accomplish by being here? _____
_____

Lifestyle challenges: Which of the following seem to sabotage your weight loss efforts:

Lack of time for planning & self	Eating late/ waking up eating	Eating too fast
Comfort/ stress eating	Liquid calories such as alcohol	Always hungry
Enjoyment of food	Specific food cravings like carbohydrates	Boredom eating
Social Events	Mindless eating/ Habit	Other:

HOW DID YOU HEAR ABOUT THE CLINIC? (Please circle any that apply)
Radio? _____ Magazine? _____ TV Station? _____ Commercial? _____
Doctors Office Referral? _____ Internet: Google Yahoo Other?

Family member, friend or co-worker? If they are a patient, they receive a $20 credit.
Who? _____