Cresencia D. Banzuela, MD
NOBESO® Weight Program
260 E. Ontario Ave Ste. 204, Corona, CA 92879
T (951) 272-6595 F (951) 272-3872

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____Date of Birth: _____ Date:_____
Phone: (Home/Cell)_____ (Work) _____ Gender: M / F
Referred By: _____

How does your weight affect your life and health? _____
_____
_____

Weight History

When did you become overweight?
☐ Childhood ☐ Teens ☐ Adulthood ☐ Pregnancy ☐ Menopause
Did you ever gain more than 20 pounds in less than 3 months? Y / N If so, how long ago? _____
As best you can remember, how much did you weigh one year ago? _____
Five years ago? _____ 10 years ago? _____

Triggers for your weight gain (check all that apply):
☐ Stress ☐ Marriage ☐ Divorce ☐ Illness ☐ Medication abuse ☐ Travel ☐ Injury
☐ School work ☐ Insomnia ☐ Quitting (circle all that apply): Smoking / Alcohol / Drugs

Previous weight-loss programs (check all that apply):
☐ Weight Watchers ☐ Nutrisystem ☐ Jenny Craig ☐ LA Weight Loss ☐ Atkins
☐ South Beach ☐ Zone diet ☐ Medifast ☐ Dash diet ☐ Paleo diet
☐ HCG diet ☐ Mediterranean diet ☐ Ornish diet ☐ Other: _____

What was your maximum weight loss? _____
What are your greatest challenges with dieting? _____
_____

Have you ever taken medication to lose weight? (check all that apply):
☐ Phentermine (Adipex) ☐ Meridia ☐ Xenecal/Alli ☐ Phen/Fen
☐ Phendimetrazine (Bontril) ☐ Topamax ☐ Saxenda ☐ Diethylpropion
☐ Bupropion (Wellbutrin) ☐ Belviq ☐ Qsymia ☐ Contrave
Other: _____
What worked? _____
What didn't work? _____
Why or why not? _____

Nutritional History

How often do you eat breakfast? _____ days per week at _____:_____ a.m.
Number of times you eat per day: _____
Do you get up at night to eat? Y / N If so, how often? _____ times
Daily servings of: Vegetables _____ Fruits _____ Meat _____ Dairy _____
Sweet beverages (check all that apply):
☐ Soda ☐ Juice ☐ Sweet tea ☐ Coffee/tea If so, how many times per day? _____

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Number of times per week you eat fast food: Breakfast _____ Lunch _____ Dinner _____
Eating triggers (check all that apply):
☐ Stress ☐ Boredom ☐ Anger ☐ Seeking Reward ☐ Parties ☐ Eating Out
☐ Fast Food ☐ Other: _____

Food cravings:
☐ Sugar ☐ Chocolate ☐ Starches ☐ Salty ☐ High Fat ☐ Large Portions
Favorite foods: _____

Medical History
Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____

How many hours do you sleep per night? _____ How many times do you get up during the night? _____
Do you feel rested in the morning? _____

Past medical history (check all that apply):

☐ Heart attack	☐ Angina	☐ Gall bladder stones	☐ Sleep apnea
☐ High blood pressure	☐ Stroke	☐ Indigestion/reflux arthritis	☐ Thyroid
☐ High cholesterol	☐ Diabetes	☐ Celiac disease	☐ Anxiety
☐ High triglycerides	☐ Gout	☐ Pancreatitis	☐ Depression
☐ Infertility	☐ Polycystic Ovarian Syndrome		

☐ Cancer (type/s): _____
Have you ever be diagnosed with an eating disorder? Y / N If yes, which one? _____

Past surgical history (check all that apply):
☐ Gastric bypass ☐ Gastric banding ☐ Gastric sleeve ☐ Gall bladder ☐ Heart bypass
☐ Hysterectomy ☐ Other: _____

Medications (list all current medications and dosages):
_____ _____ _____ _____
_____ _____ _____ _____

Allergies:
(Medications)_____
(Food)_____

Social History
Smoking: ☐ Never ☐ Current smoker (_____ packs/day) ☐ Past smoker (quit _____ years ago)
Alcohol: ☐ Never ☐ Occasional ☐ Regularly (_____ drinks per day)
Prior treatment for alcoholism? Y / N
Drugs: ☐ Never ☐ Current ☐ Past ☐ Type of drugs: _____
Marijuana: ☐ Never ☐ Current user (_____ times/day)

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Family History

Obesity (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Diabetes (check all that apply): ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Daughter ☐ Son

Other (check all that apply): ☐ High blood pressure ☐ Heart disease ☐ High cholesterol ☐ High triglycerides ☐ Stroke ☐ Thyroid problems ☐ Anxiety ☐ Depression ☐ Bipolar disorder ☐ Alcoholism ☐ Cancer (type/s): _____

Other: _____

Gynecologic History

Age periods started? _____ Age periods ended _____

Periods are: Regular / Irregular Heavy / Normal / Light

Number of pregnancies: _____ Number of children: _____

Age of first pregnancy: _____ Age of last pregnancy: _____

System Review

(Check all that apply)

☐ Acne	☐ Skin pigmenting/ Skin tags	☐ Joint pain (Hip or Knee)
☐ Skin rash	☐ Cough	☐ In-toeing/ Leg Bowing
☐ Snoring	☐ Shortness of breath	☐ Chest pain
☐ Difficulty breathing when flat	☐ Fainting/Blacking out	☐ Palpitations
☐ Swelling ankles/extremities	☐ Abdominal pain	☐ Bloating
☐ Constipation	☐ Diarrhea	☐ Food intolerance
☐ Dysphagia/difficulty swallowing	☐ Indigestion	☐ Nausea/vomiting
☐ Increased appetite	☐ Decreased appetite	☐ Heartburn
☐ Gas and bloating	☐ Urinary frequency/urgency	☐ Slow urine flow
☐ Nighttime urination	☐ Loss of urine control	☐ Blood in stools
☐ Back pain (upper)	☐ Back pain (lower)	☐ Facial Numbness
☐ Muscle aches/pain	☐ Dizziness	☐ Headaches
☐ Seizures	☐ Weakness/low energy	☐ Anxiety
☐ Depression	☐ Insomnia	☐ Memory loss
☐ Inability to concentrate	☐ Apnea	☐ Nervousness
☐ Loss of interest	☐ Cold intolerance	☐ Excessive sweating
☐ Hair changes	☐ Heat intolerance	☐ Blood clots
☐ Fatigue/tiredness	☐ Recent weight loss more than 10 pounds	
☐ Mood Changes	☐ Recent weight gain more than 10 pounds	

(Men only)

☐ Difficulty with erections	☐ Loss of interest in sex	☐ Low testosterone

(Women only)

☐ Absence of periods	☐ Hot flashes	☐ Change in bladder habits
☐ Abnormal/excessive menstruation	☐ Facial hair	☐ Loss of interest in sex
☐ Difficulty getting pregnant		

Comments: _____