Dr. Nader Said
Board Certified in Anesthesiology
Board Certified in Pain Management
Diplomat of Board of Obesity Medicine

MEDICAL HISTORY

Name: ---------- **Age:** **F / M** **Date:**---------

Allergy to medications or foods:

Current medications:

Past Medical History of:

High blood pressure----------	Heart Attack----------
Irregular heartbeats----------	Gastrointestinal disease----------
Lung disease----------	Sleep apnea----------
Glaucoma----------	Seizure----------
Kidney disease----------	Liver Disease----------
Thyroid----------	Diabetes----------

PastSurgicalHistory:----------

Gynecology:
Number of Pregnancies
Menstrual cycle: Regular: Y N Date of last one: ----------

Psychiatric History:
Circle one; Depression / Anxiety / Bipolar / Binge eating

Family History of Overweight:

Weight History:

Present Weight ---------- one year ago---------- at age 20----------
Desired Weight---------- in how long----------
Previous weight loss attempts----------
Previous Appetite suppressants----------

Eating History:
Eating in house or out? ----------
You cook or not? Y N
Do you have groceries list? Y N
Time of the day you are eating most----------
Do you awaken hungry during the night? Y N
Do you eat a lot under stress? Y N

Social and activity level:
Do you consume a lot of Alcohol / Coffee / Tea / Tobacco?
Are you satisfied at work?

Are you calm, impatient, or moderate?
Are you active, not, or moderate?
How many hours do you sleep at night?

Preventive medical care:

Breast Exam, Pelvic Exam, Pap smear, Rectal Exam, Immunization