

REYNOSO MD

Medical Weight Loss Center

hCG History Form

(PLEASE PRINT)

Client Name _____ Date _____

Current Medications

(include all prescription, over the counter, vitamins/supplements)

Name of Med/Vit/Supp	Strength	Dosage/How often taken

Allergies to Medications

None

Drug	Type of Reaction (ex: hives, upset stomach, etc.)

Past History

Check if you have had or currently have any of the following conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Bipolar Disorder |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Colitis | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Bladder Disease | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> HIV/Aids | <input type="checkbox"/> Food Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle/Joint Pain |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Tobacco Use |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Swelling of Extremity |
| <input type="checkbox"/> Prostate Problems | <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Other _____ | | |

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Surgical History

(ex: hernia, hysterectomy, tonsillectomy etc.) None

Type of Surgery	Date

Social History

Yes	No			
		Do you use tobacco?	Frequency:	Quantity:
		Do you use alcohol?	Frequency:	Quantity:
		Do you use caffeine?	Frequency:	Quantity:
		Do you use recreational drugs?	Frequency:	Quantity:

Family History

Check if any health problems exist and enter family member(s) relationship to you

- Heart Disease _____ Diabetes _____
 High Blood Pressure _____ Cancer _____
 Gastrointestinal _____ Thyroid Problems _____
 Other _____

Females Only

Yes	No	
		Are you or is there a possibility that you could be pregnant?
		Are you nursing?
		Are you on birth control? If yes, what type:
		Are you taking any fertility drugs?
		Are your menstrual cycles regular?
Date of Last Period:		Date of Last Pap Smear :

Other Concerns/Comments

Client Signature _____ Date _____