Gill Family Medicine
Health & Wellness

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Patient Intake Form

Patient's Name_____ Age: _____ Date _____

Date of Birth _____ Cell Phone: _____ Home Phone: _____

Address: _____ Email: _____

City _____ State: _____ Zip _____

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 look:

_____

Describe previous methods of weight loss (e.g. diets, pills, injections, hypnosis, acupuncture and describe your results:

_____

Where and when do you do most of your overeating?

_____

_____

Please make any comments that you think might be helpful:

_____

_____

Do you currently have any medical concerns? Please List:

_____

_____

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