Aikana
ESTHETIC CENTER

PUR Beauty LLC|Aikana Esthetic Center
5103 Backlick Rd. Unit C Annandale VA, 22003
Medical Director:Priya Thirumlai MD,FACOG,FACS

NEW PATIENT MEDICAL HISTORY FORM

Weight Loss

Name:(First)_____(Last)_____ (MI)_____
Date of Birth: _____/_____/_____ Date of Visit: _____/_____/_____
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 (circle all that apply):

- ☐ Stress
- ☐ Illness
- ☐ Night Shift Work
- ☐ Marriage
- ☐ Medication Abuse
- ☐ Insomnia
- ☐ Divorce
- ☐ Travel Injury
- ☐ Quitting Smoking/Alcohol/Drugs

Previous weight-loss programs :

- ☐ 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)
- ☐ Topamax
- ☐ Qsymia
- ☐ Meridia
- ☐ Saxenda
- ☐ Contrave
- ☐ Xenecal/Alli
- ☐ Diethylpropion
- ☐ Tirzepatide/Wegovy
- ☐ Phen/Fen
- ☐ Bupropion(Wellbutrin)
- ☐ Semaglutide/Ozempic
- ☐ Phendimetrazine(Bontril)
- ☐ Belviq
- ☐ Other_____

What worked? _____

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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

Food 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: _____
Exercise type: _____
Duration: _____ hours _____ minutes Number of times per week: _____
What prevents you from exercising? _____
How many hours do you sleep per night? _____ Do you feel rested in the morning? _____

Past medical history (circle all that apply):

- ☐ Heart attack
- ☐ Angina
- ☐ Gall bladder stones
- ☐ Sleep apnea
- ☐ High blood pressure
- ☐ Stroke
- ☐ Indigestion/reflux
- ☐ Arthritis
- ☐ Thyroid
- ☐ High cholesterol
- ☐ Diabetes
- ☐ 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):

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- ☐ Gastric bypass
- ☐ Gastric banding
- ☐ Gastric sleeve
- ☐ Heart bypass
- ☐ Hysterectomy
- ☐ Cosmetic Surgery _____
- ☐ 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)

Family History

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

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

Other (check all that apply):

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Anxiety
- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Alcoholism
- ☐ Depression
- ☐ 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

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(Check all that apply)

- ☐ 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
- ☐ Blood in stools
- ☐ Back pain (upper)
- ☐ Back pain (lower)
- ☐ Joint pain Muscle aches/pain
- ☐ Dizziness
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness/low energy
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Memory loss
- ☐ Inability to concentrate
- ☐ Mood changes
- ☐ Nervousness
- ☐ Cold intolerance
- ☐ Excessive sweating
- ☐ Hair changes
- ☐ Heat intolerance
- ☐ Blood clots
- ☐ Fatigue/tiredness
- ☐ Absence of periods
- ☐ Hot flashes
- ☐ Change in bladder habits
- ☐ Abnormal/excessive menstruation
- ☐ Facial hair
- ☐ Recent weight loss more than 10lbs
- ☐ Recent weight gain more than 10lbs
- ☐ Acne
- ☐ Skin rash
- ☐ Cough

Comments:_____