



Dr. C. Joe Northup M.D. FACS
3050 Mack Rd. Street
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(513) 682-6980 office
(513) 981-5783 fax

ADULT MEDICAL DATA (AGE 14 & UP)

Date _____

The more we know about you, the better medical care we can provide. This information will be kept strictly confidential. Please complete all pages.

Name _____ Sex: M / F Marital Status: S M D W

Occupation _____ Employer _____

Email Address _____ Birthdate ____ / ____ / ____

Your Family:

Next of Kin _____ Relationship _____ Phone: _____

Address (Next of Kin) _____

Primary Care Physician: _____ Number: _____

Referring Physician (if any and specialty): _____ Number: _____

Preferred Pharmacy: _____ Number: _____

Your Medical Information

Allergies (medication, foods, plants, etc. *Please note type of reaction*)

Medical Problems

<input type="checkbox"/>	Hypertension (high blood pressure)	<input type="checkbox"/>	Diabetes, Type _____	<input type="checkbox"/>	Stroke (TIA)
<input type="checkbox"/>	Hyperlipidemia (high cholesterol)	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	Reflux (GERD)
<input type="checkbox"/>	Coronary Artery Disease (heart)	<input type="checkbox"/>	Arrythmia (irreg. Heart rate)	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Atrial Fibrillation (A. Fib)	<input type="checkbox"/>	Emphysema (COPD)	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Hypothyroidism (low thyroid)	<input type="checkbox"/>	Anxiety disorder/panic attacks	<input type="checkbox"/>	Cancer, Type _____
<input type="checkbox"/>	Polycystic Ovarian Syndrome	<input type="checkbox"/>	Arthritis, where _____	<input type="checkbox"/>	Migraine headaches
<input type="checkbox"/>	Previous heart attack (MI)	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	Seizure disorder
<input type="checkbox"/>	Polycystic Ovarian Syndrome	<input type="checkbox"/>	Sleep apnea, CPAP/BiPAP?	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	Previous DVT or PE (blood clot)	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	Hernia, Type _____	<input type="checkbox"/>	Gout

List all others:



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Blood Relative's Family Medical History (write in which relative including grandparents, parents, brothers, sisters, children, etc. Please indicate maternal (mother's side) or paternal (father's side))

- Hypertension (high blood pressure) _____
- Hyperlipidemia (high cholesterol) _____
- Coronary Artery Disease _____
- Stroke _____
- Diabetes _____
- Cancer (type) _____
- Blood clots _____
- Migraine headaches _____
- Seizure disorder _____
- Alcoholism, Drug use _____
- Mental illness, Depression _____
- Emphysema (COPD) _____
- Asthma _____
- Kidney Disease _____
- Arthritis _____
- Glaucoma _____

Weight History

Current Weight _____ Lowest Adult Weight _____

Desired Weight _____

Do you exercise? _____

If you do exercise, what do you do? How often? _____



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Previous Diet Attempts: *Please check all that apply.*

Diets:

<input type="checkbox"/>	Atkins	<input type="checkbox"/>	Cabbage Soup
<input type="checkbox"/>	Weight Watchers	<input type="checkbox"/>	The Zone
<input type="checkbox"/>	Sutcamp	<input type="checkbox"/>	South Beach
<input type="checkbox"/>	Richard Simmons	<input type="checkbox"/>	Nutritional Counseling with dietitian
<input type="checkbox"/>	Personal Trainer	<input type="checkbox"/>	Hypnosis
<input type="checkbox"/>	LA Weight Loss	<input type="checkbox"/>	Sugarbusters
<input type="checkbox"/>	Diet Workshop	<input type="checkbox"/>	Metabolife/Herbalife
<input type="checkbox"/>	Low fat diet	<input type="checkbox"/>	Calorie restriction
<input type="checkbox"/>	Bloodtype	<input type="checkbox"/>	Low carb diet
<input type="checkbox"/>	Grapefruit	<input type="checkbox"/>	Physician supervised diet
<input type="checkbox"/>	Other	<input type="checkbox"/>	Other

Liquid Diets:

<input type="checkbox"/>	Optifast
<input type="checkbox"/>	Medifast
<input type="checkbox"/>	Slimfast
<input type="checkbox"/>	Physician's Weight Loss

Diet Medications:

<input type="checkbox"/>	Alli
<input type="checkbox"/>	Ephedrine
<input type="checkbox"/>	Fen-phen
<input type="checkbox"/>	Redux
<input type="checkbox"/>	Meridia
<input type="checkbox"/>	Adipex
<input type="checkbox"/>	Dexedrine
<input type="checkbox"/>	Xenical

Other: _____



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24 Hour Diet Recall

Please list all foods and quantities eaten in a 24 hour period. Be precise in listing portions and provide time of day.

Breakfast

Snack

Lunch

Snack

Dinner

Snack