Medical Weight Loss Program Medical History Form

Name: ____________________ Age:____ Sex: M F

Family physician: ____________________ Phone: ____________________

Present status:

1. Are you in good health to the best of your knowledge? Yes No
2. Are you currently under a doctor's care? Yes No
   If yes, for what? ____________________
3. Are you taking any medications? Yes No
   What: ____________________ Dosages: ____________
   What:____________________ Dosages: ____________
4. Any allergies to any medications? Yes No
   ____
5. History of high blood pressure? Yes No
6. History of diabetes? Yes No
   At what age were you diagnosed? ________
7. History of heart attack or chest pain? Yes No
8. History of swollen feet? Yes No
9. History of frequent headaches? Yes No
   Migraines? Yes No Medications for headaches: ____________________
10. History of constipation (difficulty having bowel movements)? Yes No
11. History of glaucoma? Yes No
12. Gynecologic history:
    Pregnancies: Number: __________ Dates: ____________________
    Vaginal delivery or C-section (specify): ____________________
    Menstrual: Onset: ______________
    Duration: ______________
    Are they regular: Yes No
    Pain associated: Yes No
    Last menstrual period: ____________________

Hormone Replacement Therapy: Yes No
If yes, what: ______________________________
Birth control? Yes No
Type: ______________________________
Last Check Up: ______________________________

13. Serious injuries? Yes No
Specify: ______________________________ Date: _______

14. Any surgery? Yes No
Specify: ______________________________ Date: _______
Specify: ______________________________ Date: _______

15. Family history:

	Age	Health	Disease	Cause of death (if deceased)	Overweight?
Father:					
Mother:					
Brothers:					
Sisters:					

Has any blood relative ever had any of the following:

Glaucoma:	Yes	No	Who: ____________
Asthma:	Yes	No	Who: ____________
Epilepsy:	Yes	No	Who: ____________
High blood pressure	Yes	No	Who: ____________
Kidney disease:	Yes	No	Who: ____________
Diabetes:	Yes	No	Who: ____________
Tuberculosis:	Yes	No	Who: ____________
Psychiatric disorder	Yes	No	Who: ____________
Heart disease/stroke	Yes	No	Who: ____________

Past medical history: (check all that apply)

______ Polio	______ Measles	______ Tonsillitis
______ Jaundice	______ Mumps	______ Pleurisy
______ Kidneys	______ Scarlet Fever	______ Liver Disease
______ Lung Disease	______ Whooping Cough	______ Chicken Pox
______ Rheumatic Fever	______ Bleeding Disorder	______ Nervous Breakdown
______ Ulcers	______ Gout	______ Thyroid Disease
______ Anemia	______ Heart Valve Disorder	______ Heart Disease
______ Tuberculosis	______ Gallbladder Disorder	______ Psychiatric Illness
______ Drug Abuse	______ Eating Disorder	______ Alcohol Abuse
______ Pneumonia	______ Malaria	______ Typhoid Fever
______ Cholera	______ Cancer	______ Blood Transfusion
______ Arthritis	______ Osteoporosis	______ Other: ____________

Nutrition evaluation:

1. Present weight: ________ Height (no shoes): ________ Desired weight: ___________
2. In what timeframe would you like to be at your desired weight? _________________________
3. Birth weight: _____ Weight at 20 years of age: ________ Weight one year ago: ______
4. What is the main reason for your decision to lose weight? _______________________

   ____
5. When did you begin gaining excess weight? (Give reasons, if known): ___________________

   ____
6. What has been your maximum lifetime weight (non-pregnant) and when?________________
7. Previous diets you have followed: Give dates and results of your weight loss:

   ___________________________________ ______________________________________

   ___________________________________ ______________________________________
8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or she overweight? ____
10. How often do you eat out? ____
11. What restaurants do you frequent?____
12. How often do you eat “fast foods?”____
13. Who plans meals? __________________Cooks? __________________ Shops? __________
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you shop for groceries? _________________________
16. Food allergies: ____
17. Food dislikes: ____
18. Food you crave: ____
19. Any specific time of the day or month do you crave food? ____________________________
20. Do you drink coffee or tea? Yes No How much daily? ________________________
21. Do you drink soda? Yes No How much daily? _________________________

22. Do you drink alcohol? Yes No

What? ____________________ How many drinks at a time? __________________

How many drinks per week? ______

23. Do you use a sugar substitute? ______ Butter? ___________ Margarine? _____________

24. Do you awaken hungry during the night? Yes No

What do you do? ____

25. What are your worst food habits?____

____

26. Snack Habits:

What? ____________________ How much? __________________ When? ___________

____________________ __________________ ___________

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

____

____

28. Are currently undergoing a stressful situation or an emotional upset? Explain:

____

____

29. Smoking habits: **(Choose only one.)**

___ I have never smoked cigarettes, cigars or a pipe.
___ I quit smoking ______ years ago and have not smoked since.
___ I quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
___ I smoke 20 cigarettes per day (1 pack).
___ I smoke 30 cigarettes per day (1.5 packs).
___ I smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast Typical Lunch Typical Dinner

___	___	___
___	___	___
___	___	___
___	___	___
Time eaten: ___	Time eaten: ___	Time eaten: ___
Where: ___	Where: ___	Where: ___
With whom: ___	With whom: ___	With whom: ___

31. Describe your usual energy level: ___

32. Activity level: **(Choose only one.)**
    ___ Inactive—no regular physical activity with a sit-down job.
    ___ Light activity—no organized physical activity during leisure time.
    ___ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
    ___ Heavy activity—consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
    ___ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session, 4 times per week.

33. Behavior style: **(Choose only one.)**
    ___ I am always calm and easygoing.
    ___ I am usually calm and easygoing.
    ___ I am sometimes calm with frequent impatience.
    ___ I am seldom calm and persistently driving for advancement.
    ___ I am never calm and have overwhelming ambition.
    ___ I am hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: ___

___

___

___

This information will assist us in assessing your problem areas and establishing your medical management. Thank you for your time and patience in completing this form.