Medical History Form

Name: _____ Age: _____ Sex: M F

Primary Care Physician: _____

Home Phone: _____ Cell_____ Work Phone:_____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
2. Are you under a doctor's care at the present time? Yes No
   If yes, for what? _____
3. Are you taking any medications at the present time? (Use back for more room) 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?
7. History of Heart Attack or Chest Pain? Yes No
8. History of Swelling Feet Yes No
9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____
10. History of Constipation (difficulty in bowel movements)? Yes No
11. History of Glaucoma? Yes No
12. Gynecologic History:
    Pregnancies: Number: _____ Dates: _____
    Natural 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 What: _____
    Birth Control Pills: 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	Overweight?
Father:	____	_____	_____	_____	_____
Mother:	____	_____	_____	_____	_____
Brothers:	____	_____	_____	_____	_____
Sisters:	____	_____	_____	_____	_____

Has any blood relative ever had any of the following: (Please circle)

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_____
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 time frame 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? _____

7a. previous diets you have followed: Give dates and results of your weight loss:

7b. previous medication or supplements taken for weight loss: Give dates and any side effects:

_____ _____

_____ _____

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 cola drinks? Yes No How much daily?_____

22. Do you drink alcohol? Yes No What? How much? Weekly?_____

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? _____

Name: _____ Date of Birth: _____

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

Explain: _____

28. Do you thing you are currently undergoing a stressful situation or an emotional upset?

Explain: _____

29. Smoking Habits:

Do you currently smoke? No Yes If yes how much per day?

_____

Have you smoked in the past? No Yes If yes when did you quit?

_____

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: **(answer 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: (answer only one)

You are always calm and easygoing _____

You are usually calm and easygoing._____

You are sometimes calm with frequent impatience._____

You are seldom calm and persistently driving for advancement_____

You are never calm and have overwhelming ambition._____

You are hard-driven 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 particular problem areas and establishing your medical management. Thank you for your time and patience in completing this form.