

Medical History Form

Name: _____ Age: _____ Sex: M F

Primary Care Physician: _____ 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? Yes No

- | | |
|-------------|----------------|
| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
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| What: _____ | Dosages: _____ |
| What: _____ | Dosages: _____ |
| 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

10. Migraines? Yes No

11. History of Constipation (difficulty in bowel movements)? Yes No

12. History of Glaucoma? Yes No

13. 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: _____

14. Serious Injuries: Yes No
 Specify: _____ Date: _____

15. Any Surgery: Yes No
 Specify: _____ Date: _____
 Specify: _____ Date: _____

16. Family History:

	Age	Health	Disease	Cause of Death	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: _____

7. Is your spouse, fiancé or partner overweight? Yes No
8. By how much is he or she overweight? _____
9. How often do you eat out? _____
10. What restaurants do you frequent? _____
11. How often do you eat “fast foods?” _____
12. Who plans meals? _____ Cooks? _____ Shops? _____
13. Do you use a shopping list? Yes No
14. What time of day and on what day do you shop for groceries? _____
15. Food allergies: _____
16. Food dislikes: _____
17. Food you crave: _____
18. Any specific time of the day or month do you crave food? _____
19. Do you drink coffee or tea? Yes No How much daily? _____
20. Do you drink cola drinks? Yes No How much daily? _____
21. Do you drink alcohol? Yes No
What? _____ How much? _____ Weekly? _____
22. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____
23. Do you awaken hungry during the night? Yes No
What do you do? _____
24. What are your worst food habits? _____
25. Snack Habits:
What? _____ How much? _____ When? _____

26. Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

Physical Activity and Behavioral Evaluation:

27. Describe your usual overall energy level: _____

28. 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).

29. Smoking Habits: (answer only one)

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

30. What is the one main reason for your decision to lose weight? _____

31. Why do you think you have a weight problem? Check all that apply.

- Eating the wrong kinds of foods
- Eating too much food
- Too much nibbling, snacking and/or late night eating
- Overwhelmed with life's problems and stress
- An internal metabolic or medical problem
- Not enough exercise
- I don't know

31. Do you think you are currently undergoing a stressful situation or an emotional upset that may be contributing to your eating habits now? Explain: _____

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