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Medical History Form

Name:_____ Age:_____ Sex: M F
Family Physician:_____Phone (if known):_____

Present Status

1) To the best of your knowledge, are you in good health at the present time? 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?
What:_____Dosage:_____
What:_____Dosage:_____
4) Any Allergies to any medications? _____
Do you have/had? High Blood Pressure / Heart Problems / Heart Attack / Heart Valve Problem / Stroke / Diabetes / Thyroid Issues / Liver Disease / Kidney Disease / Depression / Anxiety / Arthritis / Stomach Issues Intestine Issues / Neurological Disease / Asthma / COPD / Anemia / Cancer / Other: _____

5) Hospital Admissions/Serious Injuries:
Specify:_____ Date:_____
Specify:_____ Date:_____

6) Surgical History:
Specify:_____Date:_____
Specify:_____Date:_____

7) Gynecologic History: Pregnancies: # _____ Dates: _____
Natural Delivery or C-Section (specify): _____
When was the first day of your last menstrual period? _____
Birth Control Method:_____

8) Family History:

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OBESITY
Father:					
Mother:					
Brothers:					
Sisters:					

Family Members With: High Blood Pressure / Heart Disease / Stroke / Diabetes / Thyroid Issues / Liver Disease / Kidney Disease / Depression / Anxiety / Arthritis / Neurological Disease / Lung Disease / Anemia / Cancer / Other: _____

9) In what time frame would you like to be at your desired weight?_____

10) What is the main reason for your decision to lose weight?

_____

_____

11) When did you begin gaining excess weight? (Give reasons, if known)_____

_____

_____

12) What has been your maximum lifetime weight (non-pregnant) and when? _____

_____

_____

13) Previous diets you have followed: Give dates and results of your weight loss:

_____ _____

_____ _____

14) How often do you eat out? _____

15) How often do you eat "fast foods"? _____

16) Who plans meals? _____ Cooks? _____ Shops?_____

17) Food allergies:_____ Food dislikes:_____

18) Food(s) you crave: _____

19) Any specific time of the day or month do you crave food?_____

20) Do you drink alcohol? YES NO What?_____ How much? _____Weekly?_____

21) Do you awaken hungry during the night? YES NO What do you do? _____

22) What are your worst food habits? _____

23) When you are under stress, do you tend to eat? Explain: _____

24) Do you smoke or have you ever smoked in the past? If so, how much?_____

25) Describe your usual energy level:_____

26) Do you exercise regularly? _____

27) Please describe your general health goals and improvements you wish to make:_____

_____