



Changing Your Weighs

Medical History Form

Name: _____ Age: _____ Sex: M F

Family Physician: _____ Phone: _____

Chief Complaint:

What brings you to our office? _____

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: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

What: _____ Dosage: _____

4. Any allergies to any medications? Yes No

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
Diagnosed at what age? _____

7. History of Depression or Anxiety Yes No

8. History of DVT / Pulmonary Embolism / Clotting Disorder Yes No

9. History of Heart Attack or Chest Pain? Yes No

10. History of Swelling Feet? Yes No

11. History of Frequent Headaches? Yes No
Migraines? Yes No Medications for Headaches: _____

12. History of Constipation/Diarrhea/IBS (difficulty in bowel movements)? Yes No

13. History of Glaucoma? Yes No

14. 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

What: _____

Birth Control Pills: Yes No

Type: _____

Last Pap Smear: _____

15. Serious Injuries: Yes No

Specify: _____ Date: _____

16. Date of last mammogram _____ Normal? Yes No

17. Date of last colonoscopy _____ Result? Normal / Polyp(s) / Other

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 | _____ Cancer | _____ Blood Transfusion |
| _____ Arthritis | _____ Osteoporosis | _____ Other: _____ |

Any Surgery: Yes No

Specify: _____ Date: _____

Specify: _____ Date: _____

Specify: _____ Date: _____

Specify: _____ Date: _____

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: _____

Social History:

1. Marital Status: _____
2. Occupation: _____
3. 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).
4. Illicit drug use: _____

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? _____

7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

8. Is your significant other 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 regular soda? 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? _____

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

28. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

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-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.