MEDICAL HISTORY FORM

NAME: _____ DOB: _____ AGE: _____ SEX: M F

PRIMARY CARE PHYSICIAN: _____ Released signed (send updates)

ADDRESS: _____ CELL PHONE: _____

PRESENT STATUS:

1. Are you in good health, 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 _____

   (Use back of sheet to list additional medications if needed)

4. Any known allergies to medications? YES NO

5. Any history of High Blood Pressure? YES NO

6. Any history of Diabetes? Type: _____ YES NO

7. Any history of Heart Attack or other Cardiovascular Issues? YES NO

8. Any history of Gout or Kidney Stones? Other Kidney Problems? YES NO

9. Any history of frequent Headaches? YES NO

   Medications for Headaches: _____

10. Any history of Constipation (difficulty in bowel movement)? YES NO

11. Any history of Cancer? YES NO

11. Gynecologic History: Pregnancies - Number: _____ Dates: _____

Are periods regular? YES NO

Any pain associated with periods? YES NO

Last menstrual period: _____ Last Gynecologic Exam: _____

Hormone Replacement Therapy? YES NO Type: _____

Birth Control Pills? YES NO Type: _____

12. Any serious injuries? YES NO

Specify: _____ Date: _____

13. Any Surgeries? YES NO

Specify: _____ Date: _____

Specify: _____ Date: _____

NUTRITIONAL EVALUATION:

1. Present weight _____ Present height (no shoes) _____ Desired weight _____

2. In what time frame would you like to be at your desired weight _____

3. 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. (a) Previous diets you have followed. Give dates and results of your weight loss

_____

_____

(b) Previous medications or supplements taken for weight loss. Give dates and any side effects.

_____

8. Is your spouse, fiancée, or partner overweight? YES NO

By how much is he (or she) overweight? _____

9. How often do you eat out? _____

10. What restaurants do you eat at frequently? _____

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 do you shop for groceries? _____ what day? _____

15. Food Allergies: _____

16. Food Dislikes: _____

17. Foods You Crave: _____

18. Any specific time of the day or month that you crave food? YES NO

_____

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? _____ How often? _____

22. Do you use a sugar substitute? YES NO

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

YES NO Explain _____

27. Do you think you are currently undergoing a stressful situation or an emotional upset? YES NO

Explain: _____

28. Smoking Habits: Do you currently smoke? YES NO

If yes, how much per day? _____

Have you smoked in the past? YES NO

If yes, when did you quit? _____

29. Typical Eating Habits:

Breakfast	**Lunch**	**Dinner**
Time Eaten:	Time Eaten:	Time Eaten:
Where:	Where:	Where:
With Whom:	With Whom:	With Whom:

30. Describe your usual energy level: _____

31. 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.

32. Behavior Style: **(Answer Only One)**

__ I am always calm and easy-going

__ I am usually calm and easy-going

__ 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-driven and can never relax

33. Please describe your general health goals and improvements you wish to make.

_____

_____

34. What do you want to remember on this journey? What is your 'Why Statement"?

_____

_____

35. Who may we thank for your referring you:

_____