

# Medical History Form

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

## Present Status

Are you in good health at the present time to the best of your knowledge? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you under a doctor's care at the present time? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, for what? \_\_\_\_\_

Name of Doctor \_\_\_\_\_

## Medical History:

(check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> High Blood Pressure            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> High Cholesterol               | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Eating Disorder      |
| <input type="checkbox"/> Thyroid Disease                | <input type="checkbox"/> Asthma/Lung Disease   | <input type="checkbox"/> TB                   |
| <input type="checkbox"/> Heart Disease                  | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Gastric Reflux       |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Gall Bladder Disorder | <input type="checkbox"/> Heart Valve Disorder |
| <input type="checkbox"/> Depression/Psychiatric Illness |  |   |
| <input type="checkbox"/> Other _____                    |  |   |

## Gynecologic History:

Pregnancies: Number: \_\_\_\_\_ Dates: \_\_\_\_\_

Natural Delivery or C-Section (specify): \_\_\_\_\_

Last menstrual period: \_\_\_\_\_

Last Check Up: \_\_\_\_\_

## Any Surgeries:

\_\_\_\_\_ Yes \_\_\_\_\_ No

Specify: \_\_\_\_\_ Date \_\_\_\_\_

Specify: \_\_\_\_\_ Date \_\_\_\_\_

## Are you taking any medications at the present time?

\_\_\_\_\_ Yes \_\_\_\_\_ No

What: \_\_\_\_\_ Dosage: \_\_\_\_\_ What: \_\_\_\_\_ Dosage: \_\_\_\_\_

What: \_\_\_\_\_ Dosage: \_\_\_\_\_ What: \_\_\_\_\_ Dosage: \_\_\_\_\_

Hormone Replacement: \_\_\_\_\_ Yes \_\_\_\_\_ No Type \_\_\_\_\_

Birth Control Pills: \_\_\_\_\_ Yes \_\_\_\_\_ No Type \_\_\_\_\_

## Any allergies to any medications?

\_\_\_\_\_ Yes \_\_\_\_\_ No

List: \_\_\_\_\_

## Family History:

	Age	Health	Disease	Cause of Death	Overweight?
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother 1	_____	_____	_____	_____	_____
Brother 2	_____	_____	_____	_____	_____
Sister 1	_____	_____	_____	_____	_____
Sister 2	_____	_____	_____	_____	_____

**Diet History:**

Previous diets you have followed:

Give dates and results of your weight loss:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What is your desired weight: \_\_\_\_\_

In what time frame would you like to be at your desired weight? \_\_\_\_\_

Weight at 20 years of age: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_

What is the main reason for your decision to lose weight? \_\_\_\_\_

When did you begin gaining excess weight? (Give reasons, if known): \_\_\_\_\_

Typical Breakfast

Typical Lunch

Typical Dinner

Time eaten: \_\_\_\_\_

Time eaten: \_\_\_\_\_

Time eaten: \_\_\_\_\_

How often do you eat out? \_\_\_\_\_

What restaurants do you frequent? \_\_\_\_\_

How often do you eat "fast foods?" \_\_\_\_\_

Who plans meals? \_\_\_\_\_ Cooks? \_\_\_\_\_ Shops? \_\_\_\_\_

Food allergies: \_\_\_\_\_

Food dislikes: \_\_\_\_\_

Food you crave: \_\_\_\_\_

Any specific time of the day or month do you crave food? \_\_\_\_\_

Do you drink coffee or tea? \_\_\_\_ Yes \_\_\_\_ No How much daily? \_\_\_\_\_

Do you drink regular cola drinks? \_\_\_\_ Yes \_\_\_\_ No How much daily? \_\_\_\_\_

Do you drink diet cola drinks? \_\_\_\_ Yes \_\_\_\_ No How much daily? \_\_\_\_\_

Do you use a sugar substitute? \_\_\_\_\_ Butter? \_\_\_\_\_ Margarine? \_\_\_\_\_

Do you awaken hungry during the night? \_\_\_\_ Yes \_\_\_\_ No

What are your worst food habits? \_\_\_\_\_

Snack Habits:

What? \_\_\_\_\_ How much? \_\_\_\_\_ When? \_\_\_\_\_

**Exercise History:**

Do you exercise \_\_\_\_\_ Yes \_\_\_\_\_ No

Type: \_\_\_\_\_ Number of days per week: \_\_\_\_\_ Duration: \_\_\_\_\_

**Social History:**

Are you employed \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, occupation \_\_\_\_\_

Do you smoke \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, how much daily \_\_\_\_\_

Past smoking \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, you quit \_\_\_\_\_ years ago.

Do you drink alcohol? \_\_\_\_\_ Yes \_\_\_\_\_ No

What? \_\_\_\_\_ How much? \_\_\_\_\_ Weekly? \_\_\_\_\_

Is your spouse, fiancée or partner overweight? \_\_\_\_\_ Yes \_\_\_\_\_ No

If so, by how much? \_\_\_\_\_

Is he or she supportive of your desire to lose weight? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

\_\_\_\_\_

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

\_\_\_\_\_

Energy level: \_\_\_\_\_

List Hobbies: \_\_\_\_\_