

Medical History Form

Name: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
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 _____

Blood Type:

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: _____

Are you interested in an appetite suppressant medication?: Yes _____

Have you ever been prescribed an appetite suppressant medication by a doctor? _____ Yes _____ No

If so, which one? _____

at what dose if known? _____

when did you last take this medication? _____

Are you taking any vitamins at this time? _____ Yes _____ No

If so, which ones? _____

what dose if known? _____

Have you ever had a seizure? _____ Yes _____ No

Have you ever been diagnosed with anorexia or bulimia? _____ Yes _____ No