Medical History Form

IT IS CRUCIAL THAT YOU COMPLETE THIS FORM BEFORE YOUR FIRST VISIT AND MAIL/FAX/BRING IT TO US IN ADVANCE OF YOUR APPOINTMENT. WITHOUT IT YOUR INITIAL VISIT MAY NEED TO BE RESCHEDULED!

Name: ______________________________________ Date of birth______ Age:____ Sex: M F

Family Physician: ____ Phone: ______________

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: ____ Dosages: ___________________
   What:____ Dosages: ___________________

4. Any allergies to any medications? Yes No
   If yes, please list medications and effects (i.e. hives, shortness of breath, etc.)

____

____

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age were you diagnosed? _________

7. History of Heart Attack or Chest Pain? Yes No
   History of shortness of breath? Yes No

8. History of Swelling Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No
   Dizziness? Yes No
   Fatigue? Yes No

10. History of Constipation (difficulty in bowel movements)? Yes No

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _________________ Dates: _____________________________
    Natural Delivery or C-Section (specify): ______________________________________
    Menstrual: Age at Onset: _________Numbers of menses per year__________________
    Duration: ____________days____

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 Check Up: ____
Abnormal hair growth Yes No
Hair loss Yes No
Recent changes in sexual drive Yes No

13. Serious Injuries: Yes No
Specify: ____ Date: _________

14. Any Surgery: Yes No
Specify: ____ Date: _________
Specify: ____ Date: _________

15. 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: ______________________________
Alcoholism	Yes	No	Who: ______________________________

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	_______ Malaria	_______ Typhoid Fever
_______ Cholera	_______ Cancer	_______ Blood Transfusion
_______ Arthritis/Joint Pain	_______ Osteoporosis	________Dry skin
________Depression	________Mood Swings	________Heartburn

_______Nausea/Vomiting _______Frequent colds/viruses _______Increase in Skin Tags
_______Hypoglycemia Other: ______________

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:

   _______________________________________ ____

   _______________________________________ ____

   What was the toughest hurdle for you during your last weight loss attempt?______________________

   ____

   Have you found it difficult to lose weight even with exercise? [ ] Yes [ ] No

   What were some of the most important things that you learned during your last weight loss attempt?

   ____
8. Is your spouse, fiancée or partner overweight? Yes No N/A
9. By how much is he or she overweight? ____
10. How often do you eat out? ____
11. What restaurants do you frequent?____
11. How often do you eat “fast foods?”____

    How often do you eat fresh fruits and vegetables?_______________________________________
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: ____
Are you hungrier when you eat breakfast? [ ]Yes [ ] No
Do you find it difficult to stop eating starches and sweets once you start? [ ]Yes [ ]No

19. Any specific time of the day or month do you crave food? (i.e. close to period) ___________________

20. Do you drink coffee or tea? Yes No How much daily? ____________________________________

21. Do you drink cola drinks? 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? Y N Hungrier when you eat starches and sugars? Y N

What do you do? ____
Do you awaken with a headache if you have eaten starches and/or "sweets" the day before? Y N

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:

____

Do you eat because you are hungry or for comfort? ____

29. 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 up to 20 cigarettes per day (1 pack).
____ You smoke 30 cigarettes per day (1-1/2 packs).
____ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast | Typical Lunch | Typical Dinner

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. Do you have trouble sleeping Yes No
If yes, how long have you had trouble sleeping? __________
How often do you have trouble sleeping ____ nights per week
How does this affect you during the day? ____
____
Do you sleep restlessly? Yes No
Do you snore loudly? Yes No

35. 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.