Weight Loss Medical History Form

Patient Name: _____ Date of Birth: _____

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? _____

Are you taking any prescription or over the counter medications or vitamins/supplements? *Yes / No*

If yes, please list including name of medication, dosage, frequency, and indication:

_____taken for: _____

_____taken for: _____

_____taken for: _____

_____taken for: _____

_____taken for: _____

Do you have any known drug, food, or other allergies: *Yes / No*

If yes, what? _____

Weight and Lifestyle History

What is your desired weight? _____ When was the last age you were this weight? _____

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

What was your weight at age 18? _____

What is the highest weight you have ever been? _____

What are your main reasons for your decision to lose weight?

_____

_____

Previous Diets you have followed, including dates and results:

_____

_____

_____

Is your spouse or significant other overweight? *Yes / No / N/A*

How often do you eat out? _____

What foods do you crave? _____

Salty or Sugary Foods? _____

Is there a specific time of day or month that you crave food? _____

How many coffees, teas, colas, or energy drinks do you drink daily (please specify)? _____

_____

Do you awake hungry during the night? _____

What are your worst food habits? _____

_____

Do you overeat due to stress? *Yes / No*

Do you think you are currently undergoing a stressful situation? *Yes / No*

If yes, please explain:

_____

How frequently do you exercise (including type and minutes exercised)?

_____

Do you enjoy any types of exercise, sports, or other types of physical activity?

_____

Do you have a history of:

High Blood Pressure? *Yes / No*

Diabetes (what age? ____) *Yes / No*

Heart Attack? *Yes / No*

Other heart disease? *Yes / No*

Stroke or TIA? *Yes / No*

Swelling in Feet or Hands? *Yes / No*

Frequent Headaches? *Yes / No*

Constipation? *Yes / No*

Glaucoma? *Yes / No*

Gall Bladder Disease? *Yes / No*

Anorexia, Bulimia, or other diagnosed eating disorder? *Yes/ No*

Do you have any other medical problems not listed? *Yes / No*

If yes, please explain: _____

_____

Psychiatric Disorder? *Yes / No*

Dementia or Limited Cognitive Ability? *Yes / No*

Kidney disease? *Yes / No*

Liver disease? *Yes / No*

Drug or Alcohol Abuse? *Yes / No*

Seizure disorder? *Yes / No*

Cancer? *Yes/ No*

Polycystic Ovarian Syndrome? *Yes / No*

Thyroid disease? *Yes / No*

Gout? *Yes / No*

Surgeries: *Yes / No*

If yes, what type and when: _____

_____

Family History:

Do any blood relatives have any of the following:

Heart Disease or Stroke? *Yes / No*

High Cholesterol? *Yes / No*

Diabetes? *Yes / No*

Cancer? *Yes/ No*

Obesity? *Yes / No*

Hypertension? *Yes / No*

Kidney Disease? *Yes / No*

Psychiatric Disease? *Yes / No*

Sudden Death due to cardiac disease younger than 40? *Yes / No*

Gallbladder disorder? *Yes / No*

If yes, please specify family member and diagnosis (example: grandmother/type 2 diabetes):

_____

Social History:

What is your marital status: *Single / Married / Domestic Partnership / Divorced / Widowed*

Do you smoke? *Yes / No* Packs per Day _____

Are you a former smoker? *Yes / No* Packs per Day _____

Do you drink alcohol? *Yes / No*

If yes, what type of alcohol and approximately how many drinks per week?

_____

Do you use illicit drugs? *Yes / No*

If yes, what kind and approximately how much and how many times per week?

_____

Sleep History:

Do you snore or gasp for air at night? *Yes / No*

Are you chronically exhausted? *Yes / No*

DO you feel sleepy during the day? *Yes / No*

Do you wake up during the night? *Yes / No*

Do you have hair loss, constipation, or dry skin? *Yes/ No*

Do you have right upper abdominal or back pain after eating? *Yes / No*

Do you notice joint pain and swelling, especially after high protein meals? *Yes / No*

Do you have any additional comments or other information you believe would be helpful for us to know regarding your health or weight loss history or weight loss goals?

_____

_____

_____

Is there a particular treatment or treatments you are interested in discussing?

_____

Sign and date below:

Patient's Signature: _____Date: _____

Practitioner's Signature: _____Date: _____