Patient Medical History Form

Name: _____ Age:_____ Sex: M F

Primary Care Physician: _____Phone: _____

Primary Care physician's Address: _____

Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
   Explain a "no" answer:

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

Prescription Drugs: List all
Drug: Dosage:

Over-the-Counter medications, vitamins, supplements: List all Yes No
Product Dosage

4. Any allergies to any medications? Yes No
   Please list:

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   At what age: _____

7. History of Heart Attack or Chest Pain or other heart condition? Yes No

8. History of Swelling Feet Yes No

9. History of Frequent Headaches? Yes No
   Migraines? Yes No Medications for Headaches: _____

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

11. History of Glaucoma? Yes No

12. History of Sleep Apnea? Yes No

13. Gynecologic History:
Pregnancies: Number: _____ Dates: _____
Natural Delivery or C-Section (specify): _____
Menstrual: Onset: _____
Duration: _____
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: _____ With Whom: _____

14. Serious Injuries: Yes No
Specify (list all) Date

15. Any Surgery: Yes No
Specify: (List all) Date

16. 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: _____
Psychiatric Disorder Yes No Who: _____
Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

_____ Heart disease	_____ Measles	_____ Tonsillitis
_____ Heart Failure	_____ Mumps	_____ Pleurisy
_____ Kidney disease	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Liver diease	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	
_____ Nervous Breakdown		
_____ Ulcers	_____ Gout	_____Arthritis
_____ Thyroid Disease		
_____ Anemia	_____ Heart Valve Disorder	
_____ Tuberculosis	_____ Gallbladder Disorder	
_____ Psychiatric Illness		
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Vitamin Deficiency Type: _____		
_____ Cancer: Type: _____		
_____ Blood Transfusion		
_____ Arthritis	_____ Osteoporosis	_____ 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:

8. Is your spouse, fiancee or partner overweight? Yes No
9. By how much is he or she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent?_____
12. How often do you eat "fast foods?"_____

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 usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) you crave: _____

19. Any specific time of the day or month do you crave food? _____

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 daily? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No

What do you do? _____

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

_____

_____

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 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

_____
_____
_____
_____
Time eaten: _____
Where: _____
With whom: _____

Typical Lunch

_____
_____
_____
_____
Time eaten: _____
Where: _____
With whom: _____

Typical Dinner

_____
_____
_____
_____
Time eaten: _____
Where: _____
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. 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.