

# Medical History Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

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? \_\_\_\_\_

Are you taking any medications at the present time? Yes No

What: \_\_\_\_\_ Dosages: \_\_\_\_\_

What: \_\_\_\_\_ Dosages: \_\_\_\_\_

What: \_\_\_\_\_ Dosages: \_\_\_\_\_

What: \_\_\_\_\_ Dosages: \_\_\_\_\_

Any allergies to any medications? Yes No

History of High Blood Pressure? Yes No History of Diabetes? Yes No

History of Glaucoma? Yes No History of Heart Attack or Chest Pain? Yes No

History of Swelling Feet Yes No. History of Chronic Headaches? Yes No

Serious Injuries: Yes No

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

Any Surgery: Yes No

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

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

Please describe your general health goals and improvements you wish to make:

\_\_\_\_\_

**Past Medical History:** (check all that apply)

- |                           |                            |                         |                            |
|---------------------------|----------------------------|-------------------------|----------------------------|
| _____ Polio               | _____ Lung Disease         | _____ Arthritis         | _____ Cancer               |
| _____ Kidneys             | _____ Scarlet Fever        | _____ Liver Disease     | _____ Osteoporosis         |
| _____ Rheumatic Fever     | _____ Bleeding Disorder    | _____ Nervous Breakdown | _____ Drug Abuse           |
| _____ Ulcers              | _____ Gout                 | _____ Thyroid Disease   | _____ Eating Disorder      |
| _____ Anemia              | _____ Heart Valve Disorder | _____ Heart Disease     | _____ Gallbladder Disorder |
| _____ Psychiatric Illness | _____ Alcohol Abuse        | _____ Blood Transfusion |                            |
| _____ Other: _____        |                            |                         |                            |

**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: | _____ |

**Nutrition Evaluation:**

## Physician's Plan Weight Management Medical Clinic

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, fiancée or partner overweight? Yes No
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 shop for groceries? \_\_\_\_\_
16. Food allergies: \_\_\_\_\_ 17. Food dislikes: \_\_\_\_\_
18. Food 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? \_\_\_\_\_ 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? Yes No
28. Do you think you are currently undergoing a stressful situation or an emotional upset? Yes No

## Physician's Plan Weight Management Medical Clinic

29. Smoking Habits: Do you currently smoke? Yes            No

30. What time do you get up in your morning? \_\_\_\_\_.

31. What time do you leave for school/work? \_\_\_\_\_.

32. What time do you get home at the end of your day? \_\_\_\_\_.

33. What time do you put your head on your pillow (bedtime)? \_\_\_\_\_.

34. **Typical Breakfast**

**Typical Lunch**

**Typical Dinner**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

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

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

Where: \_\_\_\_\_

Where: \_\_\_\_\_

Where: \_\_\_\_\_

With whom: \_\_\_\_\_

With whom: \_\_\_\_\_

With whom: \_\_\_\_\_

35. Describe your usual energy level: \_\_\_\_\_

36. 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 at least 3 times per week.

37. Behavior style: **(answer only one)**

\_\_\_\_\_ You are always calm

\_\_\_\_\_ You are seldom calm and persistently driving for advancement.

\_\_\_\_\_ You are sometimes calm with frequent impatience.

\_\_\_\_\_ You are never calm and have overwhelming ambition and easygoing.

\_\_\_\_\_ You are hard-driving and can never relax.