

Patient Medical History Form

Name: _____ Age: _____ Sex: M F

Present Status:

- | | | |
|--|-----|----|
| 1. Are you in good health at the present time to the best of your knowledge?
Explain a "no" answer: | Yes | No |
| 2. Are you under a doctor's care at the present time?
If yes, for what? | Yes | No |
| 3. Are you taking any medications at the present time? | Yes | No |

Prescription Drugs: List all

Drug:	Dosage:
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<u>Over-the-Counter medications, vitamins, supplements:</u> List all	Yes	No
Product	Dosage	

- | | | |
|---|-----|----|
| 4. Any allergies to any medications?
Please list: | Yes | No |
| 5. History of High Blood Pressure? | Yes | No |
| 6. History of Diabetes?
At what age: _____ | Yes | No |
| 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?
Migraines? Yes No Medications for Headaches: _____ | Yes | No |
| 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: _____

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)

- | | | |
|--|---|--|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> 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, fiancée 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	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. 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.