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? ____

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 (non pregnant)? ____________________

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

____

____

Previous Diets you have followed, including dates and results:

____

____

____

____

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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 over eat 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 mini-stroke? 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, Bulemia, or other diagnosed Eating Disorder? Yes/ No

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

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If yes, please explain: ____

____

Psychiatric Disease? 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:

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

Do you smoke? Yes / No 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 / week?

____

Do you use illicit drugs? Yes / No

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

____

Review of Symptoms:

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 your doctor regarding your health or weight loss history or weight loss goals?

____

____

____

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

____

Thank you for taking the time to thoroughly complete this! Please be sure to sign and date below:

Patient's Signature: ____Date: _______________

Doctor's Signature: ____Date: _______________

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