

# Medical History Form

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

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

## Present Status:

1. Are you in good health at the present time to the best of your knowledge? Yes No
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  
What: \_\_\_\_\_ Dosages: \_\_\_\_\_  
What: \_\_\_\_\_ Dosages: \_\_\_\_\_
4. Any allergies to any medications? Yes No  
\_\_\_\_\_
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? 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. 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: \_\_\_\_\_

13. Serious Injuries: Yes No  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_

14. Any Surgery: Yes No  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_

15. 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: _____

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

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ 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, 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 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? 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: \_\_\_\_\_

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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.