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Physicians Weight Loss & Wellness Center
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Phone 770.431.2322 Fax 770.431.2321

Medical History Form

Name : _____ **Age :** _____ **Sex:** ◯ Male ◯ Female

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:_____Dosage:_____
What:_____Dosage:_____
What:_____Dosage:_____
What:_____Dosage:_____

4. Any allergies to any medications? Yes No
   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? Yes No

8. History of Swelling of the Feet? Yes No

9. History of Frequent Headaches? Yes No
   Migranes? 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
    Last Menstrual period:_____
    Hormone Replacement Therapy? Yes No
    What?_____
    Birth Control Pills: Yes No

Type?_____

Last Check Up?_____

13. Serious Injuries:_____
Specify:_____

14. Any Surgery: Yes No
Specify:_____
Specify:_____
Specify:_____

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:_____
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)

____Kidneys	_____Liver Disease	
____Lung Disease	_____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	
____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 age 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 result of your weight loss
   _____ _____
   _____ _____
8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is she or he overweight? _____
10. How often do you eat out?_____
11. What restaurants do you eat at? _____
12. How often do you eat fast foods?_____
13. Who plans meals?_____Cooks?_____Shops?_____
14. Do you use a shopping list? Yes No
15. Food Allergies:_____
16. Food Dislikes:_____
17. Food you crave:_____
18. Any specific time of the day or month do you crave food?_____
19. Do you drink coffee or tea? Yes No How much daily?_____
20. Do you drink cola drinks? Yes No How much daily?_____
21. Do you drink alcohol? Yes No

    What ? _____ How Much? _____ Weekly?_____
22. Do you use a sugar substitute?_____ Butter?_____Margarine?_____

23. Do you awaken Hungry during the night? Yes No

What do you do ? _____

23. What are your worst food habits? _____

24. Snack Habits:

What?_____How much?_____When?_____

25. When you are under a stressful situation at work or family related, do you tend to Eat more? Explain: _____

26. Do you think you are currently undergoing a stressful situation or an emotional Upset? Explain:

27. Smoking Habits: (answer only one)

___Do you smoke?
___You quit smoking ____years ago and have not smoked since.
___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)

28. Typical Breakfast	Typical Lunch	typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten:_____	Time Eaten:_____	Time Eaten:_____
Where:_____	Where:_____	Where:_____
With whom:_____	With whom:_____	With whom:_____

28. Describe your usual energy Level:_____

29. 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 ativities such as weekend golf, Tennis, jogging, swimming or cycling.
_____Heavy activity- consistant 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.

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

_____