Hormone Health LLC.Weight Loss

Name:_____ Date of Birth: (__ __/__ __/__ ___)

Medical History

Medication (Please include over the counter and birth control):

_____

Weight loss medications tried/taken in the past:_____

_____

Allergies: _____

Illeness:

- ☐ Anxiety
- ☐ Depression
- ☐ High Cholesterol
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Thyroid
- ☐ Migraine
- ☐ GERD
- ☐ Asthma
- ☐ Other: _____

Surgeries:_____

WEIGHT HISTORY

Motivation for weight loss:

- ☐ Appearance
- ☐ Health
- ☐ Fatigue

Other: _____

What diets/methods have you tried?_____

When did you start to gain weight?_____

Symptoms due to your present weight: _____

How much do you want to lose? _____

Reasons for being overweight (check all that apply):

- ☐ Snacking
- ☐ Sweets
- ☐ Alcohol
- ☐ Eating due to boredom
- ☐ Eating due to depression/anxiety
- ☐ Lack of exercise
- ☐ Pregnancy

Other:_____

DIETARY HISTORY

Usual 8 oz. serving of beverages per day: Sweetened tea: _____ Fruit Juice: _____ Milk:_____

Soda: _____ Diet Soda: _____ Water: _____ Alcohol: _____ Coffee: _____

Other:_____

Usual number and time of meals each day: _____

Usual number of times per week you eat in a restaurant or have fast food: _____

Usual amount of snacks and what type consumed per day: _____

EXERCISE HISTORY

List usual type and duration of exercise you perform each week: _____