Please copy and complete this form.

Medical History Form

Name: _____ Age:_____ Sex: M F
LAST FIRST MI

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: _____
   (If you need more space please use the space at the end of the form)

4. Any allergies to any medications? Yes No
   _____
   Please list.

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes
   No
   If Yes, discovered at age: _____

7. History of Heart Attack, Congestive Heart Failure or Heart Surgery? Yes No

8. History of Swelling Feet? Yes No

9. 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: Menstrual: Age at Onset: _____
    Pregnancies: Number: _____ Dates: _____
    Natural Delivery or C-Section (specify): _____

    Is period regular: Yes No Number of days period lasts_____

Date of Last menstrual period _____ If menopausal, Age at Onset_____

Hormone Replacement Therapy: Yes No
What: _____

Birth Control Pills/ IUD/Depo-Provera? (Name)_____ Yes No

13. Serious Injuries: Yes No
Specify: _____ Date: _____

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

Specify: _____ Date: _____

15. Family History:

	Age(s)	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: _____

Your 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, fiancee or partner overweight? Yes No How much overweight?_____

9. How many times a week do you eat out? _____

10. What restaurants do you frequent?_____

11. How often do you eat "fast foods" each week and which meal?_____

12. Who plans meals? _____ Cooks? _____ Shops? _____

13. Do you use a shopping list? Yes No

14. Does shopping occur (circle) Daily? Weekly? Not Planned?
Do you purchase food already cooked at the grocery store? YES NO

15. Food allergies: _____

16. Food dislikes: _____

17. Foods you crave: _____

18. Any specific time of the day or month that you crave food? _____

19. Do you drink coffee or tea? Yes No How much daily? _____

20. Do you drink regular soft drinks? Yes No How much daily? _____

21. Do you drink alcohol? Yes No

What? _____ How much? _____Daily?_____Weekly? _____

22. Do you use a sugar substitute? Which one?_____

23. Do you awaken hungry during the night? Yes No What do you eat/drink?_____
_____

24. What are your worst food habits? _____

25. Snack Habits:

What? _____ How much? _____ When? _____

_____ _____ _____

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

_____

_____

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

_____

_____

28. 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).

29.

Yesterday's Breakfast:	***Yesterday's Lunch:***	***Yesterday's Dinner:***
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

30. Describe your usual energy level: _____

31. Activity Level: **(answer only one)**

____ Inactive—no regular physical activity with a sit-down job.
____Light Activity—walk 2 times per week or less, play with kids occasionally
____Moderate activity—occasionally involved in activities such as weekend golf, tennis, walking swimming or cycling, aerobics or dance classes up to 3 times a week.
____ Heavy activity—consistent lifting, stair master, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports more than 3 times per week..

____ Vigorous activity—participation in extensive physical exercise for at least 60 minutes per session 5 times per week or more.

32. Behavior style: **(answer only one)**
    ____ You are always calm and easygoing.
    ____ You are usually calm and easygoing, occasionally impatient but not angry.
    ____ You are sometimes calm but frequently impatient; drive fast.
    ____ You are seldom calm and get angry waiting at a light or in line all the time.
    ____You are hard-driving and can never relax. Frequently upset and demanding.

33. 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.

Additional Space for Medications, Surgical/Injury Information or other specifics which might impact your success in a weight loss program:

_____.

_____.

_____.

_____.

_____.

Please copy and complete this form. Bring it with you to the **Free Orientation Class.** If you decide to join the ***Advanced Physicians Weight Management*** Program, this will be your Registration Form.

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