

Medical History Form

Name: Last _____ First _____ M _____

Date of Birth: _____ Age _____ Sex: _____ Male _____ Female

Current Medications:

Name of Medication	Strength	Directions

Any known Medication or Food Allergies? _____

YOUR present **Health Status** (*not family*)

YES NO

- ___ ___ High blood pressure
- ___ ___ Migraines?
- ___ ___ Heart Attack?
- ___ ___ Blood Clots?
- ___ ___ Breast Cancer?
- ___ ___ Ovarian Cancer?
- ___ ___ Uterine Cancer?
- ___ ___ Glaucoma?
- ___ ___ Kidney Disease?
- ___ ___ Prostate Cancer?
- ___ ___ Asthma?

YES NO

- ___ ___ Have you ever smoked?
- ___ ___ Do you currently smoke?
- ___ ___ Currently on birth control?
- ___ ___ Possibility of pregnancy?
- ___ ___ Currently breastfeeding
- ___ ___ Thyroid Disease?
If yes, Hypo? or Hyper? _____
- ___ ___ Diabetes?
If yes, Type I or Type 2? _____

What is your **Surgical History**?

YOUR past **Medical History** (*not family*)

YES NO

- ___ ___ Bulimia?
- ___ ___ Anemia?
- ___ ___ Kidney Stones?
- ___ ___ Bleeding Disorder?
- ___ ___ Cancer?
- ___ ___ Anorexia?
- ___ ___ Seizures?
- ___ ___ Gout?

YES NO

- ___ ___ Polycystic Ovarian Disease?
- ___ ___ Drug Abuse?
- ___ ___ Rheumatic Fever?
- ___ ___ Osteoporosis?
- ___ ___ ADD/ADHD?
- ___ ___ Liver Disease?
- ___ ___ Alcohol Abuse?



Medical History Form (continued)

If you answered YES to any on previous page...please explain:

Please list any other information about your medical history that we may have not asked.

Activity Self-Assessment: Check One

1. _____ **Inactive**—no regular physical activity with a sit down job.
2. _____ **Light activity**—no organized physical activity during leisure time.
3. _____ **Moderate activity**—"occasionally" involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
4. _____ **Heavy activity**—consistent lifting, stair climbing, heavy construction, etc...or "regular" participation in jogging, swimming, cycling or active sports at least 3 times per week.
5. _____ **Vigorous activity**—participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

This information will assist us in assessing your particular problem areas and establishing your medical weight loss program. Please verify that you have answered the questions in this Medical History Form truthfully and to the best of your ability.

Signature: _____ Date: _____

Witness: _____ Date: _____ Time: _____

