

Medical History Form

NAME: _____ **AGE:** _____ **SEX:** **M** **F**

Family Physician: _____ **Phone #** _____

1. Are you in good health at the present time to the best of your knowledge? **Yes** **No**
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. Do you have a history of High Blood Pressure** **Yes** **No**

6. Do you have a history of Diabetes? **Yes** **No**
If so, 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?
Medications for Headaches _____

10. History of Constipation (difficulty in bowel movements)? **Yes** **No**

11. History of Glaucoma? **Yes** **No**

12. Serious Injuries? **Yes** **No**

Specify: _____ Date _____

13. Any Surgery? **Yes** **No**

Specify: _____ Date _____

14. Family History: Age Health Disease Cause of Death Overweight?
Father: _____

Mother: _____
Brothers: _____
Sisters: _____
Sons: _____
Daughters: _____

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: _____

15. Gynecologic History: Menstrual history, age of onset _____
Cycle _____ days from start to start / Usual duration _____ days regular / irregular
Pain or cramps associated? Yes No / LMP _____ /
Are you on birth control? Yes No Type _____ Last Check up: _____
Pregnancies: Number _____ Dates: _____
Natural: _____ Cesarean: _____

16. Hormone Replacement Therapy: Yes No Type _____

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? _____