Patient Medical History Form

Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Present Status

1. Are you in good health at the present time to the best of your knowledge? ☐ Yes ☐ No
   If "no," please explain:

2. Are you under a doctor's care at the present time? ☐ Yes ☐ No
   If "yes," please explain what condition is being treated:

3. Are you taking any prescription medications at the present time? ☐ Yes ☐ No
   If "yes," please list:

Name of Medication(s)	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Are you taking any over-the-counter medications (e.g. vitamins, supplements)? ☐ Yes ☐ No
   If "yes," please list:

Name of Medication(s)	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Are you allergic to any medications? ☐ Yes ☐ No
   If "yes," please list, including reactions:

6. Have you ever experienced or been diagnosed with the following:

   High blood pressure ☐ Yes ☐ No
   Diabetes ☐ Yes ☐ No
   If "yes," at what age were you diagnosed?

Heart attack, chest pain or other heart condition	☐ Yes	☐ No
Swelling feet	☐ Yes	☐ No
Frequent headaches or migraines *If "yes," what medications do you use?*	☐ Yes	☐ No
Constipation (difficulty in bowel movements)	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No
Breathing or respiratory problems	☐ Yes	☐ No
Circulatory issues	☐ Yes	☐ No

7. Have you ever experienced any serious injuries? ☐ Yes ☐ No
   If "yes," please explain:

Injury	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Have you ever had surgery? ☐ Yes ☐ No
   If "yes," please explain:

Surgery	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you are a female, please provide your gynecologic history

9. Have you ever been pregnant? ☐ Yes ☐ No
   If "yes," please respond to the following:
   a. *How many pregnancies have you had?*

   b. *Please describe each pregnancy, including its dates, and the outcomes:*

10. Age of menarche: _____
11. Duration of your average cycle: _____
12. Are your cycles regular? ☐ Yes ☐ No
13. Do you experience pain with your cycle? ☐ Yes ☐ No
14. Date of last menstrual period: _____
15. Have you undergone hormone replacement therapy? ☐ Yes ☐ No
    If "yes," what therapy?

16. Do you take birth control pills? ☐ Yes ☐ No
If "yes," please provide medication name?

17. When was your last gynecologic exam? _____

Past Medical History

From the following, please check all conditions that you have ever been diagnosed with:

_____ 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: _____

Family History

	Age	Health	Disease	Cause of Death	Overweight?
Father:					
Mother:					
Brother(s):					
Sister(s):					

Has any biological relative ever had any of the following?

Glaucoma	☐ Yes ☐ No	Relationship_____
Asthma	☐ Yes ☐ No	Relationship_____
Epilepsy	☐ Yes ☐ No	Relationship_____
High Blood Pressure	☐ Yes ☐ No	Relationship_____
Kidney Disease	☐ Yes ☐ No	Relationship_____
Diabetes	☐ Yes ☐ No	Relationship_____
Psychiatric Disorder	☐ Yes ☐ No	Relationship_____
Heart Disease/Stroke	☐ Yes ☐ No	Relationship_____

Nutrition Evaluation

1. Present Weight: _____ Height: _____ 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? (Provide reason(s), if known): _____
_____

6. What has been your heaviest weight (non-pregnant) and when? _____

7. Previous diets you have followed: Give dates and results of your weight loss:
_____ _____
_____ _____
_____ _____
_____ _____

8. Is your spouse or partner overweight? ☐ Yes ☐ No

9. How often do you eat out? _____
10. What restaurants do you frequent? _____
11. How often do you eat fast foods? _____
12. Who plans your meals? _____ Cooks? _____ Grocery Shops? _____
13. Do you use a shopping list? ☐ Yes ☐ No
14. What time of day and on what day do you usually shop for groceries? _____
15. Do you have any food allergies? ☐ Yes ☐ No
If "yes," please list:

16. What are your primary food dislikes: _____
17. What food(s) do you crave most? _____
18. Is there any specific time of the day or month do you crave food? _____
19. Do you drink coffee or tea? ☐ Yes ☐ No
If "yes," how much daily?

20. Do you drink soft drinks? ☐ Yes ☐ No
If "yes," how much daily?

21. Do you drink alcohol? ☐ Yes ☐ No
If "yes," how many drinks do you average a week?

22. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____
23. Do you wake up hungry during the night? ☐ Yes ☐ No
If "yes", what do you do?

24. What are your worst food habits? _____

25. Please describe your typical meal:

Breakfast	Lunch Dinner	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where:_____	Where:_____	Where:_____
With Whom: _____	With Whom: _____	With Whom: _____

26. Please describe your snack habits:

Snack	Typical Portion	Time Typically Consumed
_____	_____	_____
_____	_____	_____
_____	_____	_____

27. When you are under a stressful family or work-related situation, do you tend to eat more? ☐ Yes ☐ No
If "yes," please explain:

28. Do you think you are currently undergoing a stressful situation or an emotional upset? ☐ Yes ☐ No
If "yes," please explain:

Smoking Habits

Please check only one of the following:

____ Have never smoked cigarettes, cigars or a pipe.
____ Quit smoking ___ years ago and have not smoked since.
____ Quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
____ Smoke 20 cigarettes per day (1 pack).
____ Smoke 30 cigarettes per day (1-1/2 packs).
____ Smoke 40 cigarettes per day (2 packs).

Physical Activity

1. Describe your usual energy level: _____

2. Please check the statement that best describes your activity level:
_____ Inactive—no regular physical activity with desk job.
_____ Light activity—no organized physical activity during leisure time.

_____ Moderate activity—occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.

_____ Heavy activity—consistent lifting, stair climbing, heavy construction, 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 four times per week.

Behavior style

Please check the statement that best describes your behavior**:**

_____ Always calm and easygoing.
_____ Usually calm and easygoing.
_____ Sometimes calm with frequent impatience.
_____ Seldom calm and persistently driving for advancement.
_____ Never calm and have overwhelming ambition.
_____ Hard-driving and can never relax.

Goals

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

Thank you for completing this form. This information you have provided will assist us in assessing your particular problem areas and establishing your medical management.