EGEA MEDICAL WEIGHT LOSS CENTER

Medical History Form

Name: ____ Age:__________ Sex: M F

Primary Care Physician: _______________________Home 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? (use back for more room) Yes No
   What: ____ Dosages: ______________________
   What:____ Dosages: ______________________

4. Any allergies to any medications? Yes No
   If yes, which medicine and what type of reaction?______________________________

5. History of High Blood Pressure? Yes No

6. History of Diabetes? Yes No
   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? Yes No Medications for Headaches: _______________________

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

11. History of Glaucoma? Yes No

12. Gynecologic History:
    Pregnancies: Number: _____________________ Dates: ________________
    Natural Delivery or C-Section (specify): ________________________________
    Menstrual: Onset: _______________________
    Duration: ______________________
    Are they regular: Yes No
    Pain associated: Yes No
    Last menstrual period: _________
    Hormone Replacement Therapy: Yes No
    What: _________________________
    Birth Control Pills: Yes No
    Type: _________________________
    Last Check Up: _________________________

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

14. Any Surgery: Yes No

Specify: ____________________ Date: __________

Specify: ____________________ Date: __________

Specify: ____________________ Date: __________

15. Family History:

	Age	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: ____________________

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? ____________________

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

7b. Previous medication or supplements taken for weight loss: Give dates and any side effects: ____

8. Is your spouse, fiancee or partner overweight? Yes No

9. By how much is he or she overweight? ____

10. How often do you eat out? ____

11. What restaurants do you frequent?____

12. How often do you eat "fast foods?"____

13. Who plans meals? ____________________________ Cooks? _________________ Shops? _______________________

14. Do you use a shopping list? Yes No

15. What time of day and on what day do you shop for groceries? ____

16. Food allergies: ____

17. Food dislikes: ____

18. Food you crave: ____

19. History of an eating disorder?____

20. Any specific time of the day or month do you crave food? __________________________________

21. Do you drink coffee or tea? Yes No How much daily? ____________________________

22. Do you drink cola drinks? Yes No How much daily? ________________________________

23. Do you drink alcohol? Yes No

What? _______________________________ How much? _____________________________ Weekly? ________________

24. Do you use a sugar substitute? _________ Butter? _________ Margarine? _____________________

25. Do you awaken hungry during the night? Yes No

What do you do? ____

26. What are your worst food habits? ____

27. Snack Habits:

What? _______________________________ How much? _____________________________ When? _________

_______________________________ _____________________________ _________

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

____

____

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

____

____

30. Smoking Habits: Do you currently smoke ? Yes No if yes how much per day?

Have you smoked in the past? Yes No if yes when did you quit?

31.

Typical Breakfast	Typical Lunch	Typical Dinner
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
Time eaten: ______________	Time eaten: ____________	Time eaten: ______________
With whom: _____________	With whom: ___________	With whom: ______________
Where:_________________	Where:_______________	Where:___________________

32. Describe your usual energy level: ____

33. Activity Level: **(answer only one)**
_____ Inactive—no regular physical activity with a sit-down 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, etc., or regular participation in 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 4 times per week.

34. Behavior style: **(answer only one)**
_____ You are always calm and easygoing.
_____ You are usually calm and easygoing.
_____ You are sometimes calm with frequent impatience.
_____ You are seldom calm and persistently driving for advancement.
_____ You are never calm and have overwhelming ambition.
_____ You are hard-driven and can never relax.

35. 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.

Linda Theotokatos, D.O., PLLC

Egea
MEDICAL WEIGHT LOSS CENTER