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

_____
_____
_____
_____
Time eaten: _____
With whom: _____
Where:_____

Typical Lunch

_____
_____
_____
_____
Time eaten: _____
With whom: _____
Where:_____

Typical Dinner

_____
_____
_____
_____
Time eaten: _____
With whom: _____
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


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