

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

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: _____

Name: _____ Date of Birth _____

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? _____

Name: _____

Date of Birth: _____

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, fiancée 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. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No

What? _____ How much? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

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

What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:

What? _____ How much? _____ When? _____

Name: _____ Date of Birth: _____

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

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

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

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

30. Typical Breakfast

Typical Lunch

Typical Dinner

Time eaten: _____

Time eaten: _____

Time eaten: _____

Where: _____

Where: _____

Where: _____

With whom: _____

With whom: _____

With whom: _____

31. Describe your usual energy level: _____

32. 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 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 4 times per week.

33. 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.

34. 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.