Glow Health
MEDICAL CLINIC

# Weight Management Health History

| | | | | | |
|---|---|---|---|---|---|
| **PATIENT INFORMATION** | *Last Name MI* | *First* | *Female ( ) Male ( )* | *Birth Date* | *Age* |
| | *Address* | *Apt#* *City* *State* | | | *Zip* |
| | *Home Phone* | *Cell Phone* | *Work Number* | | |
| | *E-Mail* | | *Marital Status* | *Employer* | |
| | *Height* | *Weight* | *Goal Weight?* | | |
| | *Emergency Contact* | *Relationship* | | *Phone* | |
| | *Physician* | *Address* | | *Phone* | |
| | *Who Referred You?* | *Name* | | | |

This section is for the purpose of learning more about your health history. Please read and answer all of the following questions to the best of your knowledge.

What are your Weight loss goals, including goal weight:

_____
_____
_____

What programs/diets have you tried in the past:

_____
_____
_____

What programs/diets were successful in the past and why:

_____
_____
_____

What do you think is the main reason you have been unsuccessful at losing weight or maintaining weight loss in the past?

_____
_____
_____

Patient Name: _____Date of Birth:_____

What Supplements/injections have you used in the past for weight loss?

_____
_____
_____

## Social and Health History

**General** **(Check all that apply)**

| | | | | |
|---|---|---|---|---|
| My Health is | Excellent | Good | Fair | Poor |
| My Physical fitness is | Excellent | Good | Fair | poor |

**Stress level:**

| | |
|---|---|
| I am often sad and blue | I have difficulty dealing with stress |
| I am under a lot of stress | I am fatigued all the time |
| I practice meditation/relation techniques | |

**Dietary Habits I commonly consume (check all that apply):**

| | | |
|---|---|---|
| Coffee | Regular soft drinks | Diet soft drinks |
| Minimize carbs | Avoid red meat | Minimize fat |
| Vegetarian | I try to eat healthy | No special diet habit |
| Emphasize fruits, grains, vegetables | Chips/crackers | Candy/chocolate |
| I do not eat diary/cheese | High protein diet | |

**Exercise Habits:**

| | |
|---|---|
| NO special exercise habits | I routinely exercise _____hrs/week |
| Lift weights | Aerobic exercise (jog/walk/treadmill) |
| Swim | Stretch/yoga/Tai Chi/Other |

**Tobacco Use:**

| | |
|---|---|
| I never smoked cigarettes or chewed tobacco | I smoked _____packs/day for _____years |
| I smoke cigars/pipes/ecig | I quit smoking _____(mo/years_ |
| I use recreational drugs _____type | |

Patient Name: _____Date of Birth:_____

**Alcohol Use:**

| | | |
|---|---|---|
| I never drink alcohol | I drink occasionally or socially | I drink 1 -2 drinks per day |
| I drink >2 drinks per day | I drink >4 drinks per day | |

List routine hobbies/sports/recreational activities

_____

_____

**Please check any medical conditions or health problems that you currently have or have had in the past?

| Past Medical History | | | |
|---|---|---|---|
| Artificial joint/implant | ❍ yes ❍ no | Kidney disease | ❍ yes ❍ no |
| Asthma | ❍ yes ❍ no | Lung/breathing issues | ❍ yes ❍ no |
| Back Pain or Sciatica | ❍ yes ❍ no | Mood Disorder | ❍ yes ❍ no |
| Bleeding disorder | ❍ yes ❍ no | Muscle or Joint Pain | ❍ yes ❍ no |
| Blood Clotting problem | ❍ yes ❍ no | Neck pain | ❍ yes ❍ no |
| Cancer | ❍ yes ❍ no | Osteoarthritis | ❍ yes ❍ no |
| Carpal Tunnel Syndrome | ❍ yes ❍ no | Osteoporosis/ Osteopenia | ❍ yes ❍ no |
| Chest Pain/CHF | ❍ yes ❍ no | Prostate problems | ❍ yes ❍ no |
| Chronic bronchitis | ❍ yes ❍ no | Psoriasis or eczema | ❍ yes ❍ no |
| Chronic Indigestion | ❍ yes ❍ no | Recurrent sinus infection | ❍ yes ❍ no |
| Chronic pain problems | ❍ yes ❍ no | Reproductive problem | ❍ yes ❍ no |
| Constipation/diarrhea | ❍ yes ❍ no | Rheumatoid Arthritis | ❍ yes ❍ no |
| Diabetes | ❍ yes ❍ no | Seasonal allergies | ❍ yes ❍ no |
| Eye problem - Glaucoma | ❍ yes ❍ no | Seizures Disorder | ❍ yes ❍ no |
| Fibromyalgia | ❍ yes ❍ no | Shoulder problems | ❍ yes ❍ no |
| Headache/Migraine | ❍ yes ❍ no | Skin problems/dermatitis | ❍ yes ❍ no |
| Heart Disease | ❍ yes ❍ no | Stomach Ulcers | ❍ yes ❍ no |
| Hepatitis/Liver disease | ❍ yes ❍ no | Stroke/vascular disease | ❍ yes ❍ no |
| Herniated Disc | ❍ yes ❍ no | Tendonitis | ❍ yes ❍ no |

Patient Name: _____Date of Birth:_____

| | | | |
|---|---|---|---|
| High Blood Pressure | ❍ yes ❍ no | Thyroid disease | ❍ yes ❍ no |
| Intestinal Disease | ❍ yes ❍ no | Toenail Fungus | ❍ yes ❍ no |
| Irregular Heart Beat | ❍ yes ❍ no | Trigger points | ❍ yes ❍ no |

List any additional health problems not listed above:

_____

_____

_____

_____

_____

_____

List any surgeries/operations you have had and when:

_____

_____

_____

_____

_____

Patient Name: _____Date of Birth:_____

List any prescribed medications you are currently taking (or have taken in the recent past)

| Medication Name | Date Started | Date Stopped | Dosage (# daily) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

*(If any additional medications please attach a separate page with the above info)*

Nutritional supplements, vitamins, herbs, homeopathic remedies taken:

_____

_____

_____

_____

Have you ever used Hormone Replacement Therapy or Anabolic Steroids? ❍ yes ❍ no

Medication Allergies:

_____

_____

Environmental/Food Allergies:

_____

_____

| **Preventive Tests**: | Date of last test known) | Results (if |
|---|---|---|
| Cholesterol | _____ | _____ |
| Blood Sugar | _____ | _____ |
| Bone density | _____ | _____ |
| Colonoscopy | _____ | _____ |
| Exercise stress test | _____ | _____ |

Patient Name: _____Date of Birth:_____

## Family History (Write the relationship of the relative(s) with the disease on the adjacent lines)

| | | |
|---|---|---|
| Heart Disease | ❍ yes ❍ no | _____ |
| High Blood Pressure | ❍ yes ❍ no | _____ |
| Diabetes | ❍ yes ❍ no | _____ |
| Arthritis | ❍ yes ❍ no | _____ |
| Skin disorders | ❍ yes ❍ no | _____ |
| Breast Cancer | ❍ yes ❍ no | _____ |
| Uterine/Ovarian Cancer | ❍ yes ❍ no | _____ |
| Prostate Cancer | ❍ yes ❍ no | _____ |
| Colon Cancer | ❍ yes ❍ no | _____ |
| Other Cancer | ❍ yes ❍ no | _____ |

List any other disease/condition in the family and relationship

_____

_____

_____

## Women Only

ARE YOU PREGNANT? ❍ yes ❍ no **First day** of last menstrual cycle _____

Date of last pap/pelvic/breast exam _____ Results: ❍ normal ❍ abnormal

Date of last mammogram _____ Results: ❍ normal ❍ abnormal

Are you currently taking or have you in the past taken hormones or oral contraceptives?
❍ yes ❍ no

If yes, please list all hormones and oral contraceptives you have taken and when

_____

_____

_____

Patient Name: _____Date of Birth:_____

Have you ever had any problems or concerns about taking hormone replacement therapy? yes ❍ no If yes list problems._____

How many pregnancies have you had?___ How many children?_____

Have you had a hysterectomy? ❍ yes ❍ no

If yes, were your ovaries removed? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

Have you had any menstrual irregularities? ❍ yes ❍ no

(if yes explain)

_____

_____

_____

## Men Only

Date of last prostate exam: _____

Are you concerned with loss of muscle mass, tone, or strength? ❍ yes ❍ no

Have you had problems with urination (decreased stream, frequent night urination)❍ yes ❍ no

Do you perform periodic testicular self-examination? ❍ yes ❍ no

Has your abdominal girth and weight been increasing? ❍ yes ❍ no

_____