Weight Management Health History Form

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?

_____

_____

_____

_____

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

_____

_____

_____

Food or Drug Allergies/Reaction ○ None

_____

_____

_____

Do you smoke? ○ Yes ○ NO

Have you ever smoked? ○ Yes ○ NO

If yes, how much? _____

For how long?_____

Do you drink alcohol, beer? ○ Yes ○ NO

If yes, how much? _____

Name: _____

Date of Birth: _____ AGE:_____

Address:_____

City:_____State:____Zip:_____

CellPhone:_____

Email:_____

Emergency Contact:_____

Phone:_____

Who Referred you?_____

HEALTH PROBLEMS YOU HAVE:

○ None

Check all that apply -

○ High blood pressure
○ Diabetes
○ Arthritis
○ Heart failure
○ Heart attack
○ Asthma or lung disease
○ Cancer, where
○ Stroke
○ Thyroid problem - Hypothyroid/hyperthyroid
○ High Cholesterol
○ Hepatitis (liver disease)
○ Seizures (epilepsy)
○ Blood clots
○ Anemia or sickle cell disease
○ Depression
○ Bipolar
○ Anxiety
○ Kidney Disease
○ Glaucoma/eye problem
○ Skin problem/psoriasis/dermatitis

Other: _____

_____

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SURGERIES YOU HAVE HAD:

○None

Check all that apply -

○Hysterectomy ○Ovaries removed
○Tubal ligation ○C-Section delivery
○Knee replacement ○Hip replacement
○Pacemaker inserted
○Heart bypass surgery
○Heart valve surgery
○Gallbladder removed
○Appendix removed
○Hernia repaired
○Prostate surgery
○Tonsils removed
○Cataracts removed
○Foot surgery, Bunion, hammertoe
Other:_____
_____

FAMILY HISTORY:

○Heart Disease ○Stroke
○High Blood Pressure
○Diabetes
○Uterine/Ovarian Cancer
○Breast Cancer ○Colon Cancer
○Prostate Cancer

MEDICINES YOU TAKE THAT ARE PRESCRIBED BY A DOCTOR: ○None

Drug Name	How Much	How Often

OTHER MEDICATIONS YOU TAKE:

○Aspirin 81mg ○Aspirin 325mg
○Tylenol
○Advil/Motrin/Aleve
○Allegra, Claritin, Zyrtec, Benadryl
○Sudafed ○Cold or cough syrups
○ Diet pills
○Tums, Rolaids, or antacids
Other:_____

VITAMINS, MINERALS, SUPPLEMENTS

○None ○Vitamin D
○Multivitamin ○Calcium
○Iron ○St John's Wort
○Ashwagandha ○Glucosamine
○Magnesium ○_____

My General Heath is:

○Excellent ○Good ○Fair ○Poor

My Physical Fitness is:

○Excellent ○Good ○Fair ○Poor

DIETARY HABITS: I commonly consume -

○Coffee
○Regular Soda ○Diet Soda
○Minimize Carbs ○High Protein
○Lowfat ○Vegetarian/Vegan
○Avoid Dairy/Cheese
○Chips/Crackers ○Candy/Chocolate
○Eat Snacks After Dinner/Before Bed

EXERCISE HABITS:

I exercise _____hrs/week
○Lift weights
○Aerobic (jog/walk/run/hike)
○Swim
○Pilates/Yoga
○Other

STRESS LEVEL:

○I am often sad and blue
○I am under a lot of stress
○I overeat when stressed
○I have difficulty dealing with stress
○I practice meditation/relaxation techniques
○I have a good support system