

# MY Weight > LOSS ADVANTAGE

## MEDICAL HISTORY FORM - MALE

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ SEX: MALE

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

### **PRESENT STATUS:**

1. Are you in good health, 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? YES NO  
What? \_\_\_\_\_ Dosage \_\_\_\_\_  
What? \_\_\_\_\_ Dosage \_\_\_\_\_  
(Use back of sheet to list additional medications if needed)
4. Any known allergies to medications? YES NO
5. Any history to High Blood Pressure? YES NO
6. Any history of Diabetes? YES NO
7. Any history of Heart Attack or Chest Pain? YES NO
8. Any history of Swelling Feet? YES NO
9. Any history of frequent Headaches? YES NO  
Migraines? YES NO  
Medications for Headaches: \_\_\_\_\_
10. Any history of Constipation (difficulty in bowel movement)? YES NO
11. Any history of Glaucoma? YES NO
12. Any history of issues with the Prostate? YES NO  
If yes, please explain: \_\_\_\_\_
13. Any serious injuries? YES NO  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_
14. Any Surgeries? YES NO  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_  
Specify: \_\_\_\_\_ Date: \_\_\_\_\_

15. FAMILY HISTORY:

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT?
<b>FATHER</b>					
<b>MOTHER</b>					
<b>BROTHERS</b>					
<b>SISTERS</b>					

Has any blood relative ever had 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	<input type="checkbox"/>	MEASLES	<input type="checkbox"/>	TONSILLITIS	<input type="checkbox"/>
JAUNDICE	<input type="checkbox"/>	MUMPS	<input type="checkbox"/>	PLEURISY	<input type="checkbox"/>
SCARLET FEVER	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	LUNG DISEASE	<input type="checkbox"/>
WHOOPING COUGH	<input type="checkbox"/>	CHICKEN POX	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	NERVOUS BREAKDOWN	<input type="checkbox"/>	ULCERS	<input type="checkbox"/>
GOUT	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>
HEART VALVE DISORDER	<input type="checkbox"/>	HEART DISEASE	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>
GALLBLADDER DISORDER	<input type="checkbox"/>	PSYCHIATRIC ILLNESS	<input type="checkbox"/>	DRUG ABUSE	<input type="checkbox"/>
EATING DISORDER	<input type="checkbox"/>	ALCOHOL ABUSE	<input type="checkbox"/>	PNEUMONIA	<input type="checkbox"/>
MALARIA	<input type="checkbox"/>	TYPHOID FEVER	<input type="checkbox"/>	CHOLERA	<input type="checkbox"/>
CANCER	<input type="checkbox"/>	BLOOD TRANSFUSION	<input type="checkbox"/>	ARTHRITIS	<input type="checkbox"/>
OSTEOPOROSIS	<input type="checkbox"/>	OTHER (DESCRIBE)	<input type="checkbox"/>		

**NUTRITIONAL EVALUATION:**

- Present Weight: \_\_\_\_\_ Present Height (no shoes): \_\_\_\_\_ Desired Weight: \_\_\_\_\_  
Weight one year ago: \_\_\_\_\_ Heaviest Weight: \_\_\_\_\_
- What is that main reason for you decision to lose weight?: \_\_\_\_\_

3. When did you begin gaining excess weight? (Give reasons, if known) \_\_\_\_\_  
 \_\_\_\_\_
4. What has been your maximum lifetime weight (non-pregnant) and when? \_\_\_\_\_
5. (a) Previous diets you have followed. Give dates and results of your weight loss: \_\_\_\_\_  
 \_\_\_\_\_
- (b) Previous medications or supplements taken for weight loss. Give dates and any side effects.  
 \_\_\_\_\_
6. Is your spouse, fiancée, or partner overweight?      YES   NO  
 By how much is he/she overweight? \_\_\_\_\_
7. What plans meals? \_\_\_\_\_ cooks? \_\_\_\_\_ shops? \_\_\_\_\_
8. Food Allergies: \_\_\_\_\_
9. Do you drink coffee or tea?   YES   NO   How much daily? \_\_\_\_\_
10. Do you drink cola drinks?   YES   NO   How much daily? \_\_\_\_\_
11. Do you drink alcohol?      YES   NO   How much daily? \_\_\_\_\_
12. Do you use a sugar substitute?      YES   NO
13. 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, ect., 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, four times per week.
14. Please describe your general health goals and improvements you wish to make.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

15. List what you normally eat for:

<b>BREAKFAST</b>	<b>MIDAFTERNOON</b>	<b>SNACKS</b>
<b>MIDMORNING</b>	<b>DINNER</b>	<b>BEVERAGES</b>
<b>LUNCH</b>	<b>EVENING</b>	<b>DESSERTS</b>