MY Weight Loss ADVANTAGE

MEDICAL HISTORY FORM

NAME:_____ AGE:_____ SEX: FEMALE

PRIMARY CARE PHYSICIAN:_____

WORK PHONE: _____

PRESENT STATUS:

1. Are you under a doctor's care at the present time? YES NO
   If yes, for what? _____
2. Are you taking any medications at the present time? YES NO
   What? _____ Dosage _____
   What? _____ Dosage _____
   What? _____ Dosage _____
   What? _____ Dosage _____
   What? _____ Dosage _____
   What? _____ Dosage _____
   What? _____ Dosage _____

   (Use back of sheet to list additional medications if needed)
3. Any known allergies to medications? YES NO
4. Any history to High Blood Pressure? YES NO
5. Any history of Diabetes? YES NO
6. Any history of Heart Attack or Chest Pain? YES NO
   Any history of Constipation (difficulty in bowel movement)? YES NO
7. GYNECOLOGICAL HISTORY:
   Pregnancies – Number: _____ Dates: _____
   Are periods regular? YES NO Any pain associated with periods? YES NO
   Last menstrual period:_____ Last Gynecological Exam:_____
   Hormone Replacement Therapy? YES NO Type:_____
   Birth Control Pills? YES NO Type:_____
   Specify:_____ Date:_____
8. Any Surgeries? YES NO
   Specify:_____ Date:_____
   Specify:_____ Date:_____

Specify:_____ Date:_____
Specify:_____ Date:_____
Specify:_____ Date:_____
Specify:_____ Date:_____
Specify:_____ Date:_____

9. FAMILY HISTORY:

	AGE	HEALTH	DISEASE	CAUSE OF DEATH	OVERWEIGHT?
FATHER					
MOTHER					
BROTHERS					
SISTERS					

PAST MEDICAL HISTORY – CHECK ALL THAT APPLY

CANCER	☐	MEASLES	☐	TONSILLITIS	☐
JAUNDICE	☐	MUMPS	☐	PLEURISY	☐
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	☐
POLIO	☐	BLOOD TRANSFUSION	☐	ARTHRITIS	☐
OSTEOPOROSIS	☐	OTHER (DESCRIBE)	☐		

NUTRIONAL EVALUATION:

1. Present Weight:_____ Present Height (no shoes):_____ Desired Weight:_____
   Weight one year ago:_____ Heaviest Weight:_____
2. 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. : _____

   _____

   (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
7. Who 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:

BREAKFAST	**MIDAFTERNOON**	**SNACKS**
MIDMORNING	**DINNER**	**BEVERAGES**
LUNCH	**EVENING**	**DESSERTS**