Institute for Medical Weight Loss & Nutrition

Medical History Form

Last Name: _____First:_____ Middle Initial: _____

Gender: M _____ F _____ Date of Birth: _____ Marital Status: Si ____ M____ D ____ Se____

Email Address: _____

Address: _____

City: _____ State:_____ Zip: _____

Phone# _____ Cell#_____ Work#_____

Occupation: _____ Employer: _____

How did you hear about The Institute for Medical Weight Loss & Nutrition?

Employee _____ Internet _____ M.D./Doctor _____ Magazine _____ Walk In _____ Patient/Friend _____

Do you know anyone at The Institute for Medical Weight Loss & Nutrition? If so, who? Which doctor, if any, referred you?

_____

Primary Care Physician (name, phone #): _____

Specialists (name(s), phone #(s)? _____

_____

Emergency Contact

Local Friend/Relative: _____ Relationship: _____

Phone# _____ Work# _____

Current 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? (continue on page 3, if necessary) YES NO

   Medication: _____ Dosages: _____

   Medication: _____ Dosages: _____
4. Any allergies to any medications? YES NO Specify: _____
5. Any food allergies? YES NO Specify: _____
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: _____
10. History of Sleep Apnea? YES NO
11. History of Glaucoma? YES NO

Gynecologic History

Menstrual Onset: _____ Duration: _____

Last menstrual period? _____ Are they regular? YES NO Pain associated? YES NO

Pregnancies # _____ Dates: _____

Natural Delivery or C-section? Specify: _____

Birth Control Pills: YES NO Type: _____

Hormone Replacement Therapy: YES NO What: _____

Last check up: _____

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. What is the main reason for your decision to lose weight? _____
4. What has been your maximum lifetime weight (non-pregnant) and when? _____
5. Previous diets you have followed: _____

   Give dates and results of your weight loss: _____
6. How often do you eat? _____
7. What restaurants do you frequent? _____
8. How often do you eat "fast foods"? _____
9. Who plans meals? _____ Cooks? _____ Shops? _____
10. Do you use a shopping list? YES NO
11. Foods you crave: _____
12. Do you drink sugar sweetened beverages? YES NO How much daily? _____
13. Do you drink alcohol? YES NO How much daily? _____
14. Do you awaken hungry during the night? YES NO

    What do you do? _____
15. What are your worst food habits? _____
16. Snack habits: What? _____

    How much? _____ When? _____
17. When you are under a stressful situation at work, with family, etc., do you tend to eat more: YES NO

    Explain: _____
18. Do you think you are currently undergoing a stressful situation or emotional upset? YES NO

    Explain: _____

19. Typical Breakfast: _____

Time eaten: _____ Where? _____ With whom? _____

Typical Lunch: _____

Time eaten: _____ Where? _____ With whom? _____

Typical Dinner: _____

Time eaten: _____ Where? _____ With whom? _____

Medication(s) continued from page 1

Medication: _____ Dosages: _____

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