Personal and Family Medical History

Height: _____ Weight _____ BMI _____

How many years have you been overweight? _____

What was your highest weight and when? _____

What do you attribute your weight gain to? _____

What is a realistic weight for you? _____

Have you had any previous surgery? If yes, please list below:

_____

_____

_____

_____

_____

_____

Please check the appropriate column if you or your immediate family (parents, sisters, brothers, or grandparents) have had any one of the following health problems:

	You	Family		You	Family
Diabetes			Orthopedic Problem		
High Blood Pressure			Arthritis		
Heart Attack			Gastrointestinal Problem/Reflux		
High Cholesterol			Psychiatric Disorder		
Angina (chest pain)			Depression/Anxiety		
Asthma			Eating Disorder		
Cancer			Sleep Apnea		
Kidney Disease or Bladder Problems			Drug/Substance Abuse		
Menstrual Problems			Bleeding Problems		
Other:			Other:		

Any other Medical issues? _____

_____

Current Medications:

Name: _____ Dosage: _____ How Often: _____

Name: _____ Dosage: _____ How Often: _____

Name: _____ Dosage: _____ How Often: _____

Name: _____ Dosage: _____ How Often: _____

Name: _____ Dosage: _____ How Often: _____

Do you take vitamins or supplements? Please indicate below:

☐ Multiple Vitamin ☐ Calcium ☐ Vitamin D ☐ Iron ☐ Fish Oil ☐ Vitamin C ☐ Other

Do you have allergies to medicines or environmental allergens? If yes, please list: _____

_____

Do you have any food intolerances? If yes, please list: _____

_____

Do you Smoke? Yes No If yes, how much? _____

If you smoked in the past, when did you quit? _____

Do you drink alcohol? Yes No If yes, how much? _____

Weight Loss Programs

Please check off the diets you have tried, weight changes and time frames below:

	Diet Plan/Medications	Amount Lost	Amount Regained	Duration	Year
O	Alli				
O	Atkins				
O	Dexatrim				
O	Hoodia				
O	Hydroxycut				
O	Jenny Craig				
O	Medifast				
O	Nutri-System				
O	Opti-fast				
O	Overeaters Anonymous				

	Diet Plan/Medications	Amount Lost	Amount Regained	Duration	Year
O	Slimquick				
O	Phen Fen				
O	Slim-Fast				
O	South Beach				
O	T.O.P.S				
O	Trimspa				
O	Weight Watchers				
O	Other:				

Has a physician ever supervised your attempts to lose weight? Yes No

Is yes, please list:

Doctor/Clinic Treatment Dates Type of Treatment

_____

_____

Nutrition History

Please list your daily meal regime:

Meal	Time	Place	Describe (what foods and how much)
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Other			

Do you skip meals? Is so, which ones? _____

Who prepares the meals in your house? _____

Who does the shopping? _____

Do you like to cook? _____

How many meals per week do you eat the following:

Fast foods _____ Cafeteria _____ Sit Down Restaurants _____ Frozen Meals _____

Which of the following beverages do you drink and how much?

Coffee: O Regular O Decaf O Iced How much? _____ Day _____ week

Tea: O Regular O Decaf O Iced How much? _____ Day _____ week

Juice: O Natural O Fruit Juice How much? _____ Day _____ week

Soda: O Regular O Diet How much? _____ Day _____ week

Smoothies/Protein Supplements: How much? _____ Day _____ week

Milk: O Whole O 2% O 1% O Skim O Other How much? _____ Day _____ week

Water: O Regular O Flavored How much? _____ Day _____ week

Alcohol: O Wine O Beer O Mixed How much? _____ Day _____ week