

**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:

	<b>You</b>	<b>Family</b>		<b>You</b>	<b>Family</b>
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
<input type="radio"/>	Alli				
<input type="radio"/>	Atkins				
<input type="radio"/>	Dexatrim				
<input type="radio"/>	Hoodia				
<input type="radio"/>	Hydroxycut				
<input type="radio"/>	Jenny Craig				
<input type="radio"/>	Medifast				
<input type="radio"/>	Nutri-System				
<input type="radio"/>	Opti-fast				
<input type="radio"/>	Overeaters Anonymous				

	Diet Plan/Medications	Amount Lost	Amount Regained	Duration	Year
<input type="radio"/>	Slimquick				
<input type="radio"/>	Phen Fen				
<input type="radio"/>	Slim-Fast				
<input type="radio"/>	South Beach				
<input type="radio"/>	T.O.P.S				
<input type="radio"/>	Trimspa				
<input type="radio"/>	Weight Watchers				
<input type="radio"/>	Other:				

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

If 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:  Regular  Decaf  Iced                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Tea:     Regular  Decaf  Iced                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Juice:     Natural  Fruit Juice                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Soda:     Regular  Diet                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Smoothies/Protein Supplements:                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Milk:     Whole  2%  1%  Skim  Other                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Water:  Regular  Flavored                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week

Alcohol:  Wine  Beer  Mixed                      How much? \_\_\_\_\_ Day \_\_\_\_\_ week