Please list all illnesses, diagnoses or medical conditions that you have been given:

Diagnosis or Condition	Current	Past

MEDICATION

Please list all medications (prescription and/or over-the-counter including supplements) you are currently taking and for what condition:

Medication	Condition	Dose(mg)	Times per day

SURGERIES

List below all surgical procedures:

Procedure	Diagnosis	Date Performed	Outcome

CANCER

Have you ever been diagnosed and treated for cancer? YES NO if so Date _____

If yes, what type of cancer?

_____

_____

DIABETICS

Have you ever been diagnosed by your physician with Type 1 or Type 2 Diabetes? _____

If yes, Type 1 Type 2 How long ago? _____ A1C level _____

Do you visit your physician regularly for follow up? YES NO Date of last visit _____

What medication and/or treatment regiment are you following?

_____

_____

_____

_____

Do you suffer from Chronic Constipation? YES NO

If so, for how long? _____

Do you have a history of/or currently have:

_____ Bulimia _____ Anorexia _____ Eating Disorder

FAMILY HISTORY

	Age	Health	Disease	Cause of Death	Overweight
Father					
Mother					
Brother					
Sister					

NUTRITION EVALUATION

Present Weight: _____ Height:: _____ Desired Weight::_____

In what time frame would you like to be at your desired weight? _____

How long have you been trying to lose weight? _____

When did begin to gain excess weight? (Give reasons if know)_____

_____

_____

_____

What has been your maximum lifetime weight (non-pregnant) and when? _____

Is your spouse, fiancé or partner overweight? YES NO By how much?_____

How often do you eat out? _____

Food allergies: _____

Food you crave: _____

Do you drink alcohol? YES NO What? _____ How much weekly?_____

Do you smoke? YES NO If so, how many cigarettes daily? _____

Do you use sugar substitute? YES NO If so, what kind? _____

Do you awaken hungry during the night? YES NO What do you do? _____

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, etc., or regular participation in jogging, swimming, etc at least 3 times a week.

_____ Vigorous activity - participation in extensive physical exercise for at least 60 minutes per session 4 times a week.

FOR MEN ONLY

Are you currently on hormone replacement therapy? YES NO

If yes, what do you take _____

Date of last prostate exam _____

Date of last PSA _____

FOR WOMEN ONLY

Are you currently on hormone replacement therapy? YES NO

If yes, what do you take _____

Are you pregnant or trying to conceive? YES NO

Date of last menstrual period _____

Date of last pap smear/ pelvic exam _____

Date of last mammogram _____

History of PMS: YES NO

History of endometriosis: YES NO

History of reproductive cancer: YES NO

History of ovarian cysts (Poly-Cystic Ovarian Syndrome) PCOS: YES NO

History of uterine cysts/ fibroids: YES NO

History of breast cancer: YES NO

Form of birth control: _____

Hysterectomy: YES NO

Menopause: YES NO

This information will assist us in assessing your particular problem areas and establishing your medical weight management protocol. Thank you for your time and patience in completing this form.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

IN CASE OF EMERGENCY

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____Phone:_____

Family Physician:_____Phone:_____