



GEORGETOWN
Wellness & Weightloss Clinic

Patient Medical History Form

Name: _____ Age: _____ Sex: M F

Present Status

1. Are you in good health at the present time to the best of your knowledge? Yes No
Explain a "no" answer: _____
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? Yes No

Prescription Drugs: List all

Drug:	Dosage:
_____	_____
_____	_____
_____	_____

Over-the-Counter medications, vitamins, supplements: List all Yes No

Product:	Dosage:
_____	_____
_____	_____
_____	_____

4. Any allergies to any medications? Yes No
Please List: _____
5. History of High Blood Pressure? Yes No
6. History of Diabetes? Yes No
At what age: _____
7. History of Heart Attack or Chest Pain or other heart condition? Yes No
8. History of Swelling Feet Yes No
9. History of Frequent Headaches? Yes No
Migraines? Yes No Medications for Headaches: _____
10. History of Constipation (difficulty in bowel movements)? Yes No
11. History of Glaucoma? Yes No
12. History of Sleep Apnea? Yes No

13. Gynecologic History:

Pregnancies: Number: _____ Dates: _____

Natural Delivery or C-Section (specify): _____

Menstrual: Onset: _____

Duration: _____

Are they regular: Yes No

Pain Associated: Yes No

Last menstrual period: _____

Hormone Replacement Therapy: Yes No

What: _____

Birth Control Pills: Yes No

Type: _____

Last Check Up: _____

14. Serious Injuries: Yes No

Specify (list all) Date

15. Any Surgery: Yes No

Specify: (List all) Date

16. Family History:

Age Health Disease Cause of Death Overweight?

Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Has any blood relative ever had any of the following:

Glaucoma: Yes No Who: _____

Asthma: Yes No Who: _____

Epilepsy: Yes No Who: _____

High Blood Pressure: Yes No Who: _____

Kidney Disease: Yes No Who: _____

Diabetes: Yes No Who: _____

Psychiatric Disorder Yes No Who: _____

Heart Disease/Stroke Yes No Who: _____

Past Medical History: (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Polio | <input type="checkbox"/> Measles | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Mumps | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Kidneys | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Chicken Pox |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Valve Disorder | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Gallbladder Disorder | <input type="checkbox"/> Psychiatric Illness |
| <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Alcohol Abuse |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Malaria | <input type="checkbox"/> Typhoid Fever |
| <input type="checkbox"/> Cholera | <input type="checkbox"/> Cancer | <input type="checkbox"/> Blood Transusion |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other: _____ |

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. Birth Weight: _____ Weight at 20 years of age: _____ Weight one year ago: _____
4. What is the main reason for your decision to lose weight? _____
5. When did you begin gaining excess weight? (Give reasons, if known): _____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____
7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

8. Is your spouse, fiancée or partner overweight? Yes No
9. By how much is he or she overweight? _____
10. How often do you eat out? _____
11. What restaurants do you frequent? _____
12. How often do you eat "fast foods?" _____
13. Who plans meals? _____ Cooks? _____ Shops? _____
14. Do you use a shopping list? Yes No
15. What time of day and on what day do you usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) you crave: _____

19. Any specific time of the day or month do you crave food? _____

20. Do you drink coffee or tea? Yes No How much daily? _____

21. Do you drink cola drinks? Yes No How much daily? _____

22. Do you drink alcohol? Yes No
What? _____ How much daily? _____ Weekly? _____

23. Do you use a sugar substitute? _____ Butter? _____ Margarine? _____

24. Do you awaken hungry during the night? Yes No
What do you do? _____

25. What are your worst food habits? _____

26. Snack Habits:
What? _____ How much? _____ When? _____

27. When you are under a stressful situation at work or family related, do you tend to eat more? Explain:

29. Smoking Habits: (answer only one)

- ____ You have never smoked cigarettes, cigars or a pipe.
- ____ You quit smoking ____ years ago and have not smoked since.
- ____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
- ____ You smoke 20 cigarettes per day (1 pack).
- ____ You smoke 30 cigarettes per day (1-1/2 packs).
- ____ You smoke 40 cigarettes per day (2 packs).

30. Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Time eaten: _____	Time eaten: _____	Time eaten: _____
Where: _____	Where: _____	Where: _____
With whom: _____	With whom: _____	With whom: _____

31. Describe your usual energy level: _____

32. 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 involve 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, cycling or active sports at least three times per week.
- ___ Vigorous activity - Participation in extensive physical exercise for at least 60 minutes per session 4 times per week.

33. Behavior style: (answer only one)

- ___ You are always calm and easygoing.
- ___ You are usually calm and easygoing.
- ___ You are sometimes calm with frequent impatience.
- ___ You are seldom calm and persistently driving for advancement.
- ___ You are never calm and have overwhelming ambition.
- ___ You are hard-driving and can never relax.

34. Please describe your general health goals and improvements you wish to make: _____

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