Southern California Center for Anti-aging
Hormone Replacement Therapy | Medical Weight Loss

Weight Loss- Medical History Form

Name: _____ Age:_____ Sex: M F

Family Physician: _____ Phone: _____

May we contact this practitioner? Yes No

Present 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? Yes No
   What: _____ Dosages: _____
   What:_____ Dosages: _____

4. Any allergies to any medications? Yes No
   _____

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? 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. 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: _____

13. Serious Injuries: Yes No
Specify: _____ Date: _____

14. Any Surgery: Yes No
Specify: _____ Date: _____
Specify: _____ Date: _____

15. 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:	_____
Tuberculosis:	Yes No	Who:	_____
Psychiatric Disorder	Yes No	Who:	_____
Heart Disease/Stroke	Yes No	Who:	_____

Past Medical History: (check all that apply)

_____ Polio	_____ Measles	_____ Tonsillitis
_____ Jaundice	_____ Mumps	_____ Pleurisy
_____ Kidneys	_____ Scarlet Fever	_____ Liver Disease
_____ Lung Disease `	_____ Whooping Cough	_____ Chicken Pox
_____ Rheumatic Fever	_____ Bleeding Disorder	_____ Nervous Breakdown
_____ Ulcers	_____ Gout	_____ Thyroid Disease
_____ Anemia	_____ Heart Valve Disorder	_____ Heart Disease
_____ Tuberculosis	_____ Gallbladder Disorder	_____ Psychiatric Illness
_____ Drug Abuse	_____ Eating Disorder	_____ Alcohol Abuse
_____ Pneumonia	_____ Malaria	_____ Typhoid Fever
_____ Cholera	_____ Cancer	_____ Blood Transfusion
_____ Arthritis	_____ Osteoporosis	_____ 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 shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food 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? _____ 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:

_____

_____

28. Do you think you are currently undergoing a stressful situation or an emotional upset? 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 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, 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.