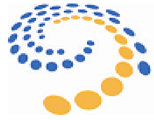


Southern California Center for Anti-aging
Hormone Replacement Therapy | Medical Weight Loss

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

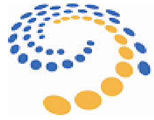
8. History of Swelling Feet Yes No

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: _____________

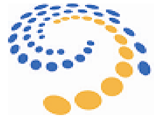
Nutrition Evaluation:

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? ___________________________________



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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)**

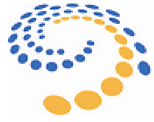
____ You have never smoked cigarettes, cigars or a pipe.
____ You quit smoking _____ years ago and have not smoked since.
____ You have quit smoking cigarettes at least one year ago and now smoke cigars or a pipe without inhaling smoke.
____ You smoke 20 cigarettes per day (1 pack).
____ You smoke 30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



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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.