MEDICAL HISTORY

NAME________________________________ DATE________________

DOB________________ AGE__________________

NAME OF REGULAR M.D.____

Please notify your regular doctor you are beginning this program.

Do you have or have you ever had: (check Yes or No) If yes please describe.

High blood pressure			
Diabetes			
Migraine headache			
Heart attack			
Stroke			
Heart rhythm disturbance			
Thyroid disorder			
Parkinson's disease			
Hepatitis/liver disease			
Gallstones or gall bladder surgery			
Kidney disease			
Seizures			
Glaucoma			
Depression or psychiatric disorder			
Manic depressive illness/bipolar disorder			
Do or purge/vomit after binging			
Do you binge?			
Alcoholism or abuse			
Recreational drug use			
Have you been told to limit your exercise for medical reasons?			
Do you take drugs for depression or anxiety?			
Food Allergies			What food?
Drug allergies			What drug(s)?
Surgery			What and When?
Surgery for Weight Control			When?
Do you smoke?			How much?
Do you Chew Tobacco or use snuff?			
Do you use alcohol?			How much?

List any other medical problems:____

Regular medications, vitamins, minerals, etc.___________________________________

Have you ever taken prescription weight loss medication?___________________________

Name of medication ________________ Month/year taken________________Doctor____________

Family History	Age if living	Age at death	Diabetes	Heart Disease	Overweight	Cause c
Father						
Mother						
Brother(s)						
Sister(s)						

Is there a history of breast cancer in your family? Yes No

Females: are you pregnant? Yes or No Last Menstrual Period ____/____/_____

____
Patient Signature

____
FNP or Physician Signature