



**Current Medications and Dosage:** Please list all medications, including non-prescription medications, vitamins and supplements.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Family History:** Please indicate in the spaces below any family members with a history of: diabetes, heart disease, cancer, kidney disease, high blood pressure, gout.

	Age	Health Problems	Age at Death	Cause
Father	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____

**Women Only**

Date of last menstrual period: \_\_\_\_\_

Have you had a hysterectomy or have gone through menopause? \_\_\_ No \_\_\_ Yes

If no, what method of birth control do you use? \_\_\_\_\_

Are you pregnant or trying to conceive? \_\_\_ No \_\_\_ Yes

Are you currently breastfeeding? \_\_\_ No \_\_\_ Yes

Are you on hormone replacement therapy? \_\_\_ No \_\_\_ Yes

If yes, what medication/supplements do you take? \_\_\_\_\_

**Review of Systems:** (Check any symptoms that you have had recently)

- |                                  |                                   |                                   |
|----------------------------------|-----------------------------------|-----------------------------------|
| <b>Constitutional</b>            | ___ Shortness of breath           | <b>Musculoskeletal</b>            |
| ___ Fever or chills              |                                   | ___ Muscle aches                  |
| ___ Excessive/Poor Appetite      | <b>Gastrointestinal</b>           | ___ Muscle weakness               |
| ___ Dehydration                  | ___ Nausea or vomiting            | ___ Backache                      |
| <b>Ears, Nose, Mouth, Throat</b> | ___ Constipation                  | ___ Joint discomfort or stiffness |
| ___ Earache or ringing in ears   | ___ Diarrhea                      | <b>Neurologic</b>                 |
| ___ Sore throat                  | ___ Abdominal discomfort          | ___ Headache                      |
| ___ Sinus infection              | ___ Bloating or excess gas        | ___ Dizziness                     |
| <b>Cardiovascular</b>            | ___ Black bowel movements         | ___ Numbness or tingling          |
| ___ Chest discomfort             | ___ Hemorrhoids                   | ___ Tremor or shaking             |
| ___ Irregular or rapid heartbeat | <b>Genitourinary</b>              | ___ Fainting or blackouts         |
| ___ Swelling of legs or ankles   | ___ Excess urination              | ___ Difficulty walking            |
| <b>Integumentary</b>             | ___ Difficultly urinating         | ___ Sleep disturbances            |
| ___ Moles or skin problems       | ___ Red or bloody urine           | ___ Seizures                      |
| ___ Abnormal lumps or growths    | <b>Gynecological</b>              | <b>Psychiatric</b>                |
| ___ Breast lumps                 | ___ Menstrual cramping            | ___ Sadness or depression         |
| ___ Nausea or vomiting           | ___ PMS symptoms                  | ___ Anxiety or nervousness        |
| <b>Respiratory</b>               | <b>Endocrine</b>                  | ___ Suicidal or violent thoughts  |
| ___ Cough                        | ___ Excessive thirst or urination | ___ Hallucination                 |
|                                  | ___ Intolerance of hot or cold    |                                   |
|                                  | ___ Excessive perspiration        |                                   |



If you had to describe the biggest issues you face in losing your weight what would they be:

- 1.
- 2.
- 3.

Is your weight negatively impacting your life today? Please explain:

- Keeping me from doing things I want to because I don't feel good about my appearance
- Cannot fit into my clothes
- Cannot do things I would like because I don't have the energy to function
- Marriage or relationship is suffering because I don't feel attractive
- Impacting my career

What weight loss products or services have you tried in the past and how successful were they for you in meeting your goals? Check and provide input for any that apply:

	<u>Length of time</u>	<u>Lbs lost</u>	<u>Reason for stopping</u>
<input type="checkbox"/> Diet aids (over the counter)	_____	_____	_____
<input type="checkbox"/> Prescription diet aids	_____	_____	_____
<input type="checkbox"/> Weight Watchers	_____	_____	_____
<input type="checkbox"/> Jenny Craig	_____	_____	_____
<input type="checkbox"/> NutriSystems	_____	_____	_____
<input type="checkbox"/> Slim Fast	_____	_____	_____
<input type="checkbox"/> Curves	_____	_____	_____
<input type="checkbox"/> Medifast	_____	_____	_____
<input type="checkbox"/> South Beach Diet	_____	_____	_____
<input type="checkbox"/> Atkins Diet	_____	_____	_____
<input type="checkbox"/> Other. Please List and explain	_____	_____	_____

Other than your weight do you have other health related challenges that you would like to address? Have you taken any steps to address these?

Sleep: \_\_\_\_\_

Stress: \_\_\_\_\_

Lack of energy: \_\_\_\_\_

Depression: \_\_\_\_\_

Mood swings: \_\_\_\_\_

Libido: \_\_\_\_\_

Hot flashes/night sweats: \_\_\_\_\_

How would you best describe your diet today? And your diet challenges? \_\_\_\_\_

\_\_\_\_\_

Are there other people in your home with weight issues? If so, who? \_\_\_\_\_

Do you have an idea of how many calories you need to consume each day to maintain your current weight? \_\_\_\_\_

How would you best describe your level of activity/exercise today? \_\_\_\_\_