Medical History Form

Name: ______________________________________
Drug Allergies: ________________________________
Current Medications: ____________________________
____
____
____
____
Alcohol: Y/N How much? ________________________
Smoke: Y/N How much? _________________________
Drugs: Y/N What, how much? _____________________
Medical History:

__ high blood pressure
__diabetes
__stroke
__seizures
__cancer
__thyroid disease
__anorexia/bulimia
__depression
__bipolar
__kidney stones
__asthma
__high cholesterol
__chest pain/heart disease
__ heart attack
__anxiety
__narcolepsy
__glaucoma
__other: _______________

Family history: ___________________________________
____
____

Lowest weight:________
Heaviest weight:_______

Other weight loss programs tried:

__Weight Watchers	__Jenny Craig
__Atkins	__South Beach
__Nutrisystem	__diet pills
__SlimFast/Optifast	__Overeaters Anonymous
__TOPS	__ other

How often do you eat out per week?__________________

How much do you typically spend on a meal out?______

How motivated are you to lose weight?

1 2 3 4 5 6 7 8 9 10
Not very **extremely**

Why do you want to lose weight (be as specific as possible)?

____
____
____
____
____
____

How did you hear about us?___________________________