
# Patient Medical AND Metabolic History Form

Name: _____ Age:_____ Sex _____

**Present Status:**

1. Do you feel you are in good health at the present time? Yes ◯ No ◯

   If "no" can you explain why? _____

2. Are you under another doctor's care at the present time? Yes ◯ No ◯
   Who? For what?

3. Are you taking any medications at the present time? Yes ◯ No ◯

Prescription Drugs: Please list all

Drug: Dosage: On File _____

Over-the-Counter medications, vitamins, supplements: List all On File_____

Product Dosage

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 or other heart condition? Yes ◯ No ◯

8. History of Swelling Feet Yes ◯ No ◯

9. History of Frequent Headaches or Migraines? Yes ◯ No ◉

10. History of Constipation (difficulty in bowel movements)? Yes ◯ No ◯

11. History of Glaucoma? Yes ◯ No ◯

12. History of Sleep Apnea? Yes ◯ No ◯

13. 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: _____

14. Serious Injuries: Yes ◯ No ◯
    Specify (list all) Date

15. Any Surgery: Yes ◯ No ◯
    Specify: (List all) Date

16. Family History:

| | Age | Health | Disease | Cause of Death | Overweight? |
|---|---|---|---|---|---|
| Father: | | | | | |
| Mother: | | | | | |
| Brother: | | | | | |
| Brother: | | | | | |
| Brother: | | | | | |
| Sister: | | | | | |
| Sister: | | | | | |
| Sister: | | | | | |
| Son: | | | | | |
| Son: | | | | | |
| Son: | | | | | |
| Daughter: | | | | | |
| Daughter: | | | | | |
| Daughter: | | | | | |

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: _____ |
| 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, fiancee 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 usually shop for groceries? _____

16. Food allergies: _____

17. Food dislikes: _____

18. Food(s) 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 daily? _____ 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: PLEASE SEE RAPA

33. Please describe your general health goals and improvements you wish to make: _____

_____

_____

_____

34. Which of the following statements is THE ***MOST*** accurate? (Pick only one)

_____ I believe weight may affect my health, but I am not ready to make any changes at this time

_____ I have been thinking about making changes to be healthier

_____ I have made plans or scheduled an appointment to discuss a plan to be healthier

_____ I am working every day on a plan to be healthier

_____ I am meeting my goals and working every day to maintain my health

_____ I have made changes and went off track, but I am ready to try again

35. During the last 3 months, did you have any single episode of eating significantly more than what most people would eat in a similar period of time?

_____ Yes _____No

NOTE**: IF YOU ANSWERED "NO"** TO QUESTION 35, **YOU MAY STOP HERE.**
THE REMAINING QUESTIONS DO NOT APPLY TO YOU.

36. Do you feel distressed about your episodes of excessive overeating?
_____ Yes _____No

The following questions apply to **the last 3 months…**

37. During episodes of excessive overeating, how often do you feel like you had no control over your eating (e.g., not being able to stop eating, feeling compelled to eat, or going back and forth for more food)?

_____ Never _____ Rarely _____ Sometimes _____ Often _____ Always

38. During episodes of excessive overeating, how often did you continue eating even though you were not hungry?

_____ Never _____ Rarely _____ Sometimes _____ Often _____ Always

39. During episodes of excessive overeating, how often were you embarrassed by how much you ate?
_____ Never _____ Rarely _____ Sometimes _____ Often _____ Always

40. During your episodes of excessive overeating, how often did you feel disgusted with yourself or guilty afterward?

_____ Never _____ Rarely _____ Sometimes _____ Often _____ Always

41. During the last 3 months, how often did you make yourself vomit to control your weight or shape?

_____ Never _____ Rarely _____ Sometimes _____ Often _____ Always

**Thank you for your time and patience in completing this form. This information will help us work together to design a plan that is customized for YOU!**