Comprehensive Client Medical History

Please answer all questions to the best of your knowledge.

Today's Date:_____/_____/_____ First Name:_______________________ Last Name:___________________________

Date of Birth: _____/_____/_____ Age:_____ ☐ Female ☐ Male eMail:________________@______________._____

Home Address:___________________________________ City:_________________ State:_____ Zip:________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name:_________________________________

Home Phone: (_____) _____ -________ Work Phone: (_____) _____ -________ Cell Phone: (_____) _____ -_________

Occupation:_________________ Employer:___________________ City:_______________ State:____ Zip:__________

Primary Care Physician:_________________________ Location:________________ Phone: (_____) _____ -_________

Date of Last Physical:____/____/____ Are you currently under a physician's care for any acute or chronic medical condition requiring regular treatment? ☐ No ☐ Yes If "Yes", please explain____

Are you taking drugs / medication for any of the following (check all that apply): ☐ Weight Loss ☐ Thyroid (_____ grams) ☐ Water Retention ☐ Stomach ☐ Blood Pressure ☐ Heart ☐ Arthritis ☐ Birth Control ☐ Other__________________

Referred to Physicians WEIGHT LOSS Centers by: ____

FAMILY HISTORY
Did either of your parents or any of your brothers or sisters ever have heart or coronary artery disease, high blood pressure, cancer, diabetes, or mental disease? ☐ No ☐ Yes *(If yes, please provide details including age at time of onset in the space provided below.)*
Father
Mother
Brothers/Sisters

PERSONAL HISTORY

HAVE YOU OR DO YOU NOW HAVE ANY OF THE FOLLOWING?	NO	YES	Please provide details of "yes" answers.
Allergies to drugs / medications / Saccharin / Nutra-Sweet®			
Pneumonia			
Pleurisy			
Rheumatic fever			
Heart disease			
Back trouble			
Arthritis			
Any bone disease			
Joint disease			
Neuritis			
Neuralgia			
Bursitis			
Sciatica			
Hair loss			
Anemia			
Jaundice			
Epilepsy			
Seizure disorder			
Migraine headaches			
Lung trouble			
Asthma / emphysema			
Hay fever			
Diabetes			

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PERSONAL HISTORY continued

HAVE YOU OR DO YOU NOW HAVE ANY OF THE FOLLOWING?	NO	YES	Please provide details of "yes" answers.
Concussion			
Head iniurv			
Knocked unconscious			
Food allergies			
Dietary restrictions			
Chemical poisoning			
Drug poisoning			
Food poisoning			
Cancer			
☐ High blood pressure ☐ Low blood pressure			
Nervous breakdown			
Hives			
Eczema			
Frequent colds			
Frequent infections			
Boils			
Any other diseases			
WOMEN ONLY	**NO**	**YES**	
Do you have periods?			
Menstrual flow: ☐ regular ☐ heavy ☐ medium ☐ light			
Do you experience any of the following before or during your period?	NO	YES	
Cramps			
Pain			
Hot flashes			
PMS			
Are you currently…	NO	YES	
Pregnant?			
Breastfeeding?			

REVIEW OF SYSTEMS

HAVE YOU OR DO YOU NOW HAVE ANY OF THE FOLLOWING?	NO	YES	Please provide details of "yes" answers.
Eye disease			
Eye injury			
Impaired sight			
Ear disease			
Ear injury			
Impaired hearing			
HAVE YOU OR DO YOU NOW HAVE TROUBLE WITH …	NO	YES	
Nose			
Sinuses			
Mouth			
Throat			
Bleeding gums			
Light headedness			
Convulsions			
Paralysis			
Dizziness			
Headaches: ☐ frequent ☐ severe			
Enlarged glands			
Thyroid: ☐ overactive ☐ underactive ☐ enlarged			
Goiter			
Skin disease			

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REVIEW OF SYSTEMS continued			
HAVE YOU OR DO YOU NOW HAVE TROUBLE WITH …	NO	YES	Please provide details of "yes" answers.
Cough: ☐ frequent ☐ chronic			
Chest pain			
Angina pectoris			
Palpitations			
Rapid pulse			
Spitting up blood			
Night sweats			
Shortness of breath: ☐ after exertion ☐ at night			
Leg cramps			
Swelling: ☐ hands ☐ feet ☐ ankles			
Varicose veins			
Extreme tiredness			
Extreme weakness			
Kidney disease			
Kidney stones			
Bladder disease			
Blood in urine: ☐ albumin ☐ sugar ☐ pus in urine			
Difficulty in urination			
Narrowed urinary stream			
Abnormal thirst			
Prostate trouble			
Stomach trouble			
Appendicitis			
Liver disease			
Gall bladder disease			
Gall stones			
Colitis			
Other bowel disease			
Hemorrhoids			
Rectal bleeding			
Black tarry stools			
Constipation			
Diarrhea			
Any change in appetite			
Any change in eating habits			
Any eating disorder			
Anorexia			
Bulimia			
Excessive use of laxatives			

HABITS			
DO YOU…	NO	YES	Please provide details of "yes" answers..
Exercise adequately			
Awaken rested			
Sleep well			
Have regular bowel movements?			
Like your work (how many hours per day? ____)			
Watch television (how many hours per day? ____)			
Read (how many hours per day? ____)			
Have a vacation (how many weeks per year? ____)			
Have you ever been treated for alcoholism or drug abuse?			

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HABITS continued

DO YOU USE ANY OF THE FOLLOWING?	NEVER	OCCAS.	FREQ.	DAILY	Please provide details of "yes" answers.
Laxatives					
Vitamins					
Sedatives, stimulants, other drugs					
Tranquilizers					
Sleeping pills, etc.					
Aspirin, etc.					
Cortisone					
Appetite suppressants					
Alcoholic beverages					
Coffee (_____cups per day)					
Cigarettes (___ packs. per day)					
Electronic Cigarettes and/or Vapes					
Cigars					
Pipe tobacco					
Chewing tobacco					

DO YOU TAKE ANY OF THE FOLLOWING?	NO	YES
Thyroid medication		
Insulin		
Tablets for diabetes		
Hormones: ☐ shots ☐ tablets/capsules ☐ topical		

SURGERY & HOSPITALIZATION

HAVE YOU HAD ANY OF THE FOLLOWING REMOVED?	NO	YES	Please provide details of "yes" answers.
Tonsils			
Appendix			
Gall bladder			
Uterus			
Ovary			
Ovaries			
Hemorrhoids			
HAVE YOU HAD ANY OF THE FOLLOWING SURGERIES?	**NO**	**YES**	
Hernia repair			
Bypass of intestine for weight control			
Stomach surgery for weight control			
Any other operations for weight control			
Have you ever been hospitalized for any illness?			

RADIOLOGY

HAVE YOU HAD ANY OF THE FOLLOWING?		NO	YES	Please provide date and disease present if applicable.
Chest	☐ x-ray ☐ cat scan ☐ mri			
Stomach	☐ x-ray ☐ cat scan ☐ mri			
Colon	☐ x-ray ☐ cat scan ☐ mri			
Gall bladder	☐ x-ray ☐ cat scan ☐ mri			
Extremities	☐ x-ray ☐ cat scan ☐ mri			
Back	☐ x-ray ☐ cat scan ☐ mri			
Other	☐ x-ray ☐ cat scan ☐ mri			

EMOTIONS

HAVE YOU OR DO YOU NOW EXPERIENCE …	NO	YES	Please provide details of "yes" answers.
Depression			
Anxiousness			
Irritability			
Jumpiness			

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EMOTIONS continued			
HAVE YOU OR DO YOU NOW EXPERIENCE …	NO	YES	Please provide details of "yes" answers.
Jitteriness			
Irritability			
Difficulty Concentrating			

WEIGHT HISTORY			
What is your current weight?	LBS		Please provide details of "yes" answers.
What was your weight one year ago?	LBS		
What was your maximum weight?	LBS		
What was your weight at 16 years old?	LBS		
What was your weight at 20 years old?	LBS		
What was your weight at 30 years old?	LBS		
How much weight have you gained in the last 3 months?	LBS		
How much weight have you gained in the last 6 months?	LBS		
Have you reduced in the past with any of the following?	NO	YES	
With medicine			
With diet			
With diet program			
What year(s)?			
What were the results?			
When did the weight return?			

EATING HABITS AND PORTION SIZES				
HOW OFTEN DO YOU…	DAILY	FREQ.	OCCAS.	NEVER
Eat breakfast				
Eat lunch				
Eat dinner				
Eat between meals				
Eat at night				

Please check how often you eat the following over the period of a week.

	DAILY	FREQ.	OCCAS.	NEVER	Frequency?	DAILY	FREQ.	OCCAS.	NEVER
Meat					Pretzels				
Fish					Ice Cream				
Cheese					Cookies				
Eggs					Peanut Butter				
Milk					Jelly or Jam				
Bread					Peas				
Cereal					Corn				
Pastries					Fast Foods				
Candy					Pizza				
Green Vegetables					Fish (Fried)				
Potatoes					Chicken (Fried)				
Fruit					Burgers				
Salads					Beer				
French Fries					Wine				
Macaroni					Liquor				
Spaghetti					Soft Drinks				
Noodles					Coffee				
Beans					Tea				
Potato Chips					Juice				

Date:____/____/____ CLIENT SIGNATURE:____

Date:____/____/____ PHYSICIAN'S SIGNATURE:____

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