WEIGHT MANAGEMENT HISTORY INTAKE

Name: ______________________________ Date: ____________
Address: ______________________ City: ______________
State: ________ Zip: ________ Occupation: ________________
Phone (Home): ________ (Work): __________(Cell): ____________
DOB: _________ Age: ___ Referral Source: ____________________
Email: ___________________________ # of Children: ________
Drug Allergies: __________________ Other Allergies: ____________
Birth Control (describe): ____________________________________
Current Meds and Vitamins: __________________________________

Surgeries: (include dates): __________________________________

Height: ________ Weight: ______
Last Blood Pressure Reading: ________ Date of BP Reading: ______
Current Treating Physician(s): ________________________________

Family History:

☐ Heart Disease ☐ High Blood Pressure ☐ Stroke ☐ Cancer ☐ Glaucoma ☐ Diabetes
☐ Epilepsy ☐ Kidney Disease ☐ Thyroid Disease ☐ Mental Disorder ☐ Osteoporosis

Women Only

Menstrual Period Y___N___ Age of onset ________ Cramps Y ___ N ___
Regular Y ___ N ___ Irregular Y ___ N ____ Date of Last Period: ______________
Duration (days) _________
Moodiness/Depression with Menses: Y___ N___ Last Pap Smear: ________
Trouble with arousal or desire: Y___ N___
Vaginal Dryness: Y___ N___ Last Mammogram: _______
Frequent vaginal infections: Y___ N___
Losing urine w/ coughing or sneezing: Y___ N___ Last Chest X-Ray:________
Have you had a Hysterectomy? Y ___ N ___ Partial ___ Total ___ Date ____________

Have you had an ablation? Y __ N __ Tubal Ligation? Y __ N __ Other? __________

Men Only

Prostate problems: Y___ N___
Trouble Urinating: Y___ N___
Decrease in size of urinating stream: Y___ N___
Number of times urinating at night: ______
Trouble with erectile dysfunction: Y___ N___
Trouble with premature ejaculation: Y___ N___
Decreased Sex Drive: Y___ N___

Personal Health History

Sleep: Difficulty falling asleep Y___ N___ Daytime drowsiness Y___ N___
Snoring Y___ N___ Early morning awakening Y___ N___
Wake Up Refreshed Y___ N___ Sleep Apnea Y___ N___

Habits

Smoke: Packs daily_____
How long? _____
Interested in stopping? ___

Coffee: Cups daily: _______
Other caffeine: ________ Diet Sodas ____

Alcohol: Type: ____________________
How many drinks _______daily _____ weekly

Personal Medical History

☐ Headache ☐ Shortness of Breath ☐ Heart Palpitations ☐ Heart Murmur ☐ Chest Pain
☐ Dizziness/Fainting ☐ Problems with Circulation ☐ Allergies/Hay Fever ☐ Asthma
☐ Bronchitis ☐ Pneumonia ☐ Ulcer ☐ GI disorder ☐ Lactose intolerance
☐ Gallbladder disease ☐ Prostate disease ☐ Bowel Irregularity ☐ Incontinence
☐ Venereal disease ☐ Frequent infections ☐ Hepatitis ☐ Anemia ☐ Arthritis
☐ Osteoporosis ☐ Nervousness ☐ Joint Pain ☐ Depression ☐ Gout ☐ Scarlet Fever
☐ Chronic Fever ☐ Rheumatic Fever ☐ Mumps ☐ Measles ☐ Rubella
☐ Polio ☐ Diphtheria ☐ Tetanus ☐ Muscle aches

Pace Makers or Any Other Medical Devices: ______________________________
Do you have sugar cravings? Y ____ N ____. Carbohydrate Cravings? Y ____ No _____
If yes, please describe: ______________________________

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Have you ever been treated for a mental disorder? Y __ No ___
If yes, please describe: ______________________________
Have you ever taken Natural Hormones or Synthetic Hormones? Y ___ No ____
If yes, name the hormones and describe your experience with the hormones:

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Have you ever been involved in a Weight Loss Program(s)? Y__ No ___
Have you ever taken weight loss medications? Y __ No __
If yes, please describe program/medications: ______________________________

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Primary Health Concern(s) /Objective(s):______________________________

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Signature: ______________________________

Date: ______________________________