Medical History

Name:_____ Date of Birth:_____

Family Physician: _____ Phone: _____

Present Status:

At the present time what is the state of your health? Excellent Good Fair Poor
Are you under a doctor's care at the present time? Yes No

If yes, why? _____

Please list all medications and supplements which you are currently taking:

_____

_____

Please list all known allergies to medications, foods or other allergens: _____

_____

Medical History (circle all that apply)

High Blood Pressure	Measles	Tonsillitis
Diabetes	Mumps	Arthritis
Heart Disease	Scarlet Fever	Osteoporosis
Frequent Headaches	Whooping Cough	Alcohol Abuse
Migraines	Bleeding Disorder	Blood Transfusion
Glaucoma	Gout	Cancer
Edema/Swelling	Constipation	Pneumonia
Depression	Gallbladder Disease	Polio
Kidney Disease	Liver Disease	Drug Abuse
Lung Disease	Chicken Pox	Eating Disorder
Rheumatic Fever	Psychiatric Illness	Tuberculosis
Ulcers	Thyroid Disease	Other:_____
Anemia	Jaundice	_____

Ob/Gyn History: ***(Female Patients)***

Menstrual: Onset age: _____
Are they Regular? Yes No
Last menstrual Period? _____
Hormone Replacement Therapy Yes No
Current Method of Birth Control? _____ Last Pap Smear (date)_____

Pregnancies Yes No Number: _____ Dates: _____

Last Mammogram (date)_____

General Medical History

Date of last physical exam_____

Please list all current illnesses: _____

Please list all serious illnesses:_____

Please list all serious injuries: _____

Please list all surgeries:_____

Family History:

Current Age Health Disease (or cause of death) Overweight?

Father: _____
Mother: _____
Brothers: _____
Sisters: _____

Has any 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? _____
Tuberculosis	Yes	No	Who? _____
Psychiatric Disorder	Yes	No	Who? _____
Heart Disease/Stroke	Yes	No	Who? _____

Nutrition Evaluation:

Present Weight: _____ Height (no shoes): _____ Desired Weight: _____

Birth Weight: _____ Weight at 20 years of age? _____ Weight one year ago? _____

What is the main reason for your decision to lose weight? _____

_____

When did you begin gaining excess weight? (Give reasons, if known) _____

_____

Previous diets you have followed (give dates and results of your weight loss):

_____

_____

_____

Is your spouse, fiancée or partner overweight? Yes No

How often do you eat? _____

What restaurants do you frequent? _____

Who plans meals? _____ Cooks? _____ Shops? _____

Food you crave: _____

Any specific time of day or month you crave food? _____

Do you drink?

Coffee or Tea	Yes	No	How much daily? _____
Cola Drinks	Yes	No	How much daily? _____
Alcohol	Yes	No	Type_____Amt_____How Often_____

Do you use a sugar substitute? Yes No

Butter	Yes	No
Margarine	Yes	No

What are your worst food habits? _____

_____

_____

When you are under a stressful situation at work or family related, do you tend to eat more? Yes No
Explain: _____

_____

_____

_____

Are you currently experiencing a stressful situation or emotional upset? Yes No
Explain: _____

_____

_____

_____

Are you a smoker or have you ever been? Yes No (If you answered yes to either question, please list number of cigarettes per day, how long, and if no longer smoking when you stopped: _____

_____

Typical Breakfast	Typical Lunch	Typical Dinner
_____	_____	_____
_____	_____	_____

Describe your energy level: _____

Activity Level: (answer only one)

_____ Inactive- No regular physical activity with a sit down job
_____ Light Activity- No organized physical activity during leisure time.
_____ Moderate Activity- Occasionally involved in activities such as weekend golf, tennis, jogging, swimming or cycling.
_____ Heavy Activity- Consistent lifting, stair climbing, heavy construction, etc., or regular participation in jogging, swimming, cycling or active sports at least three times per week.
_____ Vigorous Activity- participation in extensive physical exercises for at least 60 minutes per session.

Please describe any regular exercise in which you engage: _____

_____

Dr. Baker will review this information with you which will assist him in developing a safe and effective weight loss program individualized for you.