NAPERVILLE WEIGHTLOSS CENTER

Medical History Form

Name:_____ Age:_____ Sex: M F

Family Physician:_____ Phone#:_____

History of Present Illness:

1. Are you in good health at the present time to the best of your knowledge? Yes No

2. Are you under a doctor's care at the present time? Yes No
   If yes, for what?_____

3. Are you taking any medications at the present time? Yes No
   Med & Dosage_____ Frequency_____
   Med & Dosage_____ Frequency_____
   Med & Dosage_____ Frequency_____
   Med & Dosage_____ Frequency_____
   Med & Dosage_____ Frequency_____

4. a. Any allergies to any medications? Yes No
      If yes, please list: _____

   b. Any allergies to any foods? Yes No
      If yes, please list: _____

5. History of a Heart Attack or Chest Pain? Yes No

6. Gynecologic History:
   Have you ever been pregnant? Yes No
   Are you breastfeeding? Yes No
   Last mentstrual period ___/___/_____
   Hormone Replacement Therapy? Yes No
      If yes, what? _____
   Birth Control Pills? Yes No
      If yes, Type: _____

7. Have you had any Surgery? Yes No

   Specify: _____ Date:__/__/____

   Specify: _____ Date:__/__/____

   Specify: _____ Date:__/__/____

   Specify: _____ Date:__/__/____

8. Medical History:

Past Medical History (Circle all that apply) **Family Medical History**(Mark "x" in front all that apply)

Stroke	Lung Disease	Bleeding Disorder
High Blood Pressure	Rheumatic Fever	Gout
Diabetes	Ulcers	Heart Valve Disorder
Swelling of Feet	Anemia	Gallbladder Disease
Frequent Headaches	Psychiatric Illness	Cancer
Constipation	Drug Abuse	Thyroid Disease
Chronic Fatigue	Alcohol Abuse	Blood Transfusion
Liver Disease	Eating Disorder	Kidney Disease
Arthritis	Heart Disease	Osteoporosis
Other:_____		

Surgical Procedures:_____
_____
_____

9. Do you currently smoke tobacco? Yes No

If yes, how often?(circle choice) < 1 pack per day pack per day >1 pack per day

10. Desired Weight:_____lbs.

11. In what time frame would you like to be at your desired weight?_____

12. Weight 1 year ago:_____lbs. Weight 2 years ago:_____lbs.

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

14. When did you begin gaining excess weight? (circle choice)

1-12 months ago 1-2 years ago 3+ years ago

15. What has been your maximum lifetime weight (non-pregnant)?_____

16. Previous diets you have followed (circle all that apply): Were they successful?

Weight Watchers	Yes	No
Jenny Craig	Yes	No
OPTIFAST	Yes	No
Atkins	Yes	No
Medifast	Yes	No
Low-Fat	Yes	No
Mediterranean	Yes	No
NutriSystem	Yes	No
Other_____	Yes	No
Have you ever taken **Phentermine** before?	Yes	No

17. How often do you eat out? 1-2 times a week 2-5 times a week 5 or more times a week

18. What foods do you crave?_____

19. Do you drink (circle all that apply):
Coffee Non-Sweet Tea Sweet Tea Diet Soda Regular Soda Water

20. Do you drink alcohol? Yes No
If yes, answer the questions below: (circle answers)

What kind?	How much daily?			
Beer	Less than 1 per day	1-2 per day	3-4 per day	5+ per day
Wine	Less than 1 per day	1-2 per day	3-4 per day	5+ per day
Liquor	Less than 1 per day	1-2 per day	3-4 per day	5+ per day

21. Do you tend to snack? Yes No
If Yes, When? (circle all that apply) Morning Between Meals Evening

22. Are you currently undergoing a stressful situation or an emotional upset? Yes No
If yes, please explain_____
_____

23. What is your activity level? (circle 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 3 times a week.
Vigorous Activity	-Participation in extensive physical exercise for at least 60 minutes Per session 4 time per week.

24. Activity Level: (circle answers)
a. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? Yes No
b. Do you feel pain in your chest when you do physical activity? Yes No
c. In the past month have you had chest pain when you were not doing physical activity? Yes No
d. Do you lose your balance because of dizziness or do you ever lose consciousness? Yes No
e. Do you have a bone or joint problem (e.g. back, knee, or hip) that could be made worse by a change in physical activity? Yes No
f. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition? Yes No
g. Do you know of any other reason why you should not do physical activity Yes No
Explain:_____

This information will assist us in assessing your particular problem areas and establishing your weight loss management. Thank you for your time and patience in completing this form.