Comprehensive Client Medical History

Please answer all questions accurately to the best of your knowledge.

Name:_____ Today's Date: _____ Age: ___ Date of Birth: _____ Sex: ____

Home Address: _____ City: _____ State: ____ Zip:_____ Phone:_____

Office Address:_____ City:_____ State:____ Zip:_____ Phone:_____

EMAIL ADDRESS:_____ CELL PHONE:_____

Occupation: _____ Employer:_____

Marital Status: _____ Spouse's Name: _____

Name of Family Physician: _____ Date of Last Physical: _____

Are you currently under a physician's care for any acute or chronic medical condition requiring regular treatment?

Yes ____ Explain: _____ No _____

DRUGS OR MEDICATION YOU HAVE OR ARE NOW TAKING:

HEART MEDS_____ BLOOD PRESSURE_____
DIURETICS_____ BIRTH CONTROL _____
ARTHRITIS MEDS_____ ANTI-DEPRESANTS _____
OTC WEIGHT LOSS AIDS_____ OTHER _____

Check YES if symptom is present, or if a history of the condition exists. Check NO if not.

RESPIRATORY:	YES	NO
Shortness of breath (at rest)	____	____
Shortness of breath (activity)	____	____
Night sweats	____	____
Productive cough	____	____
Bloody cough	____	____
HISTORY OF		
Tuberculosis	____	____
Pneumonia	____	____
Asthma	____	____
Pulmonary emboli	____	____
Emphysema	____	____

CARDIOVASCULAR:		
Chest pain	____	____
HISTORY OF		
High blood pressure	____	____
Heart attack	____	____
Angina	____	____
Heart Failure	____	____
Heart murmur	____	____
Mitral valve prolapse	____	____
Low blood pressure	____	____
Edema	____	____
Peripheral vascular disease	____	____

GASTROINTESTINAL:	YES	NO
Nausea	____	____
Vomiting	____	____
Abdominal pain	____	____
Black stools	____	____
Rectal bleeding	____	____
Heartburn	____	____
Belching	____	____
HISTORY OF		
Constipation	____	____
Diarrhea	____	____
Hemorrhoids	____	____
Ulcer disease	____	____
Gallstones	____	____
Colitis	____	____
High cholesterol	____	____
High lipids	____	____

GENITOURINARY		
Nighttime frequent urination	____	____
Urgency	____	____
Difficult urination	____	____
Burning on urination	____	____
Infertility	____	____
Enlarged prostate (men)	____	____
Bloody urine	____	____
Recurrent urinary infection	____	____

LIST ALL PAST HOSPITALIZATIONS: _____

_____

LIST ALL SURGERIES: _____

MUSCULOSKELETAL:		
Aching muscles/joints	____	____
Low back pain	____	____
Limitations on mobility	____	____
HISTORY OF		
Arthritis	____	____
Muscle cramps	____	____
NEUROLOGICAL:		
Numbness	____	____
Dizziness	____	____
Headaches	____	____
HISTORY OF		
Epilepsy	____	____
Seizure disorder	____	____
Fainting	____	____
Visual limitations	____	____
Hearing limitations	____	____
OTHER:		
Diabetes	____	____
Gout	____	____
Thyroid	____	____
Depression	____	____
Bipolar/manic depression	____	____
Schizophrenia	____	____
Glaucoma	____	____
Anemia	____	____

FAMILY HISTORY: mother/father/brother/sister

Cancer _____
Heart disease _____
High blood pressure _____
Lung disease _____
Psychiatric disease _____

WOMEN-PLEASE ANSWER:

Last menses _____
Post-menopausal (y/n) _____
Last pap smear _____
Last breast exam _____
Birth Control (y/n) _____
Pregnancies _____
Miscarriages _____
Abnormal female bleeding (y/n) _____
Are you breast feeding (y/n) _____

WEIGHT HISTORY:

Age of onset of weight problems _____yr
Number of weight loss attemps _____
over last 5 years _____
Date of last weight loss attempt _____
Method _____
Outcome _____
Lowest weight: 5 years _____
10 years_____
Highest weight: 5 years_____
10 years _____
Women current dress size _____
Men current waist size _____

HOW DID YOU LEARN ABOUT US?

(PLEASE CIRCLE)

INTERNET FACEBOOK

DRIVE BY YELLOW PAGES

NEWSPAPER OTHER

FRIEND _____

PLEASE READ THIS CAREFULLY

I UNDERSTAND, IF I HAVE ANY PROBLEMS WITH THIS WEIGHT LOSS PROGRAM, I MUST CONTACT THIS FACILITY/DOCTOR AND STOP MEDICATIONS UNTIL THE DOCTOR HAS REVIEWED MY CASE AND INSTRUCTED ME AS WHAT TO DO. I ALSO UNDERSTAND THAT I AM TO NOTIFY THE WEIGHT LOSS FACILITY/DOCTOR IF MY HEALTH CHANGES OR MY DOCTOR CHANGES OR PRESCRIBES ANY NEW MEDICATIONS OR TREATMENTS FOR ANY NEW OR EXISTING CONDITIONS NOT KNOWN TO THE WEIGHT LOSS FACILITY/DOCTOR. I WILL NOTIFY MY DOCTOR OF THE MEDICATION I AM TAKING FROM THE WEIGHT LOSS FACILITY/DOCTOR.

I HAVE READ AND UNDERSTAND THE ABOVE. THE RISK AND BENEFITS OF THE PRESCRIBED MEDICATION/S HAVE BEEN EXPLAINED TO ME AND ANY QUESTIONS WERE ANSWERED TO MY SATISFACTION. FUTHERMORE, I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO FOLLOW WEIGHT LOSS INSTRUCTIONS AND FAILURE TO DO SO MAY CAUSE COMPLICATIONS TO MY HEALTH.

DATE_____CLIENT SIGNATURE_____

DATE_____DOCTOR'S SIGNATURE_____