

Medical History Form

(for office use only)

Date: _____

Name: _____ Height _____ Weight _____ BMI _____

Age _____ Sex: M F Race _____

At what weight would you feel comfortable to maintain? _____

Allergies (include medications such as Lidocaine, Antibiotics, sulfa, lactose , etc.)

Present

Medications

How many alcoholic beverages do you consume per week? _____

Do you use tobacco products? How often? _____

Have you ever been hospitalized? Yes or No

Have you had any surgeries? Yes or No

If yes, please give brief description: year diagnosis, reason for hospitalization, outcome:

Medical Problems Please check all that apply.

High Blood Pressure

Gallstones

Arthritis

Back problems

Cancer

Seizures

Stroke

Milk Allergy

Diabetes

Thyroid Problems

Ulcers

Kidney Disease

(Thrombosis Phlebitis)

High Blood Cholesterol

Liver Disease
(hepatitis)

Blood Vessel Disease
(Thrombosis Phlebitis)

Intestine (bowel) Problems

Other

Anxiety/ Depression